DWH Medical Center, PC
35 East Elizabeth Ave., Suite 3
Bethlehem, PA 18017
Phone: (610) 419-3388
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Danny Hernandez MD
Board Certified in Family Practice

AUTHORIZATION FOR RELEASE OF PATIENT INFORMATION

Name of Patient: ____

Date of Birth: _____/____/______ Social Security Number: ______-______-______

I requested and authorized, the release of healthcare information or access to the information specified below from the medical record(s) of the above-named patient.

RECORDS TO BE RELEASED FROM:

____

(Doctor, Hospital, Clinic, etc.)

(_____) _________-___________ (_____) _________-____________
Fax Phone

INFORMATION SHOULD BE RELEASED TO:

DWH MEDICAL CENTER, PC
35 East Elizabeth Ave., Suite 3
Bethlehem, PA 18017

THIS REQUEST AND AUTHORIZATION APPLIES TO:

- ☐ History & Physical
- ☐ Operative Report
- ☐ Pathology Report
- ☐ Consultation Report
- ☐ Discharge Summary
- ☐ X-Ray Report
- ☐ Emergency Room Record
- ☐ Laboratory Reports
- ☐ Entire Medical Record
- ☐ Other: ____

I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. Information used or disclosed pursuant to his authorization may be subject to re-disclosure by the recipient and is no longer protected. I understand that the specific information to be released may include, but is not limited to: history, diagnosis, and or treatment of drug or alcohol abuse, mental illness, or communicable disease, including Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency System (AIDS). I authorize the release of specific data. I also understand that this authorization may be revoked by the person giving authorization by a written and dated notice, except to the extent that disclosure of the information has been made prior to receipt of the revocation. This authorization expires one year from the date of signature unless I specifically request or otherwise revoke it. I understand I may be charged a fee for retrieval/processing and copying of my medical records.

I HAVE READ AND UNDERSTAND THIS CONSENT AND I HAVE SIGNED IT VOLUNTARILY AND OF MY OWN FREE WILL.

____

(Signature of Patient) (Signature of Parent/Legal Representative)

___________/___________/__________
(Date)

THIS AUTHORIZATION EXPIRES IN NINETY (90) DAYS AFTER IT IS SIGNED