FAMILY PRACTICE CENTER OF NEWTOWN

MEDICAL RECORDS RELEASE AUTHORIZATION

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PATIENT INFORMATION:

Patient Name:_____ Date of Birth:_____

Address:_____

Primary Number:_____ Cell Number:_____

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MEDICAL RECORDS REQUEST FROM:

Physician/Facility Name:_____

Address:_____

Phone Number:_____ Fax Number:_____

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AUTHORIZATION:

I herby grant permission for you to release confidential health information about me by releasing a copy of my medical records or a summary or a narrative of my protected health information to the Physician/ Facility listed below:

Family Practice Center of Newtown

Dr. Catherine Spratt-Turner DO

638 Newtown Yardley Road, Suite 2E, Newtown, PA 18940

Phone: 215-968-1616 / Fax: 215-860-1976

Signature:_____ Date:_____