DAVENSHIRE MEDICAL CENTER
3740 Carlisle Road
Dover, PA 17315
Phone # 717-292-3168
Fax # 717-292-3479
www.DavenshireMC.com

Record Release Authorization

Patient's **Full** Name: _____

DOB: _____/_____/_____ Social Security #:_____/_____/_____

1) Purpose of this request:
___ Personal ___ Changing Physicians ___ Continuing Care ___ Insurance/Billing

___ Other: _____

2) I hereby authorize Davenshire Medical Center to: [ ] release to [ ] receive from
(Please write the Physician/Facility Name, Address, Phone, &/or Fax #):

_____

_____

_____

_____

3) Please release the following records. (This release will expire one year from the signed date)
Please **X** all that apply:

_____**All Medical Health Records**
_____MVA or Workers Comp notes & reports
_____Other, as specified: _____

4) The following information **will be released**. Please write your initials next to any items you **do not** want to be released.

_____HIV related information
_____Mental health information (ex. Anxiety, depression, etc.)
_____Drug & Alcohol abuse or dependency information

5) You have the right to revoke this authorization in writing by sending a dated and signed letter to our Privacy Officer at the address above. Revoking this authorization will not affect your care by our physicians or the staff employed by Davenshire Medical Center.

By signing below, I understand the nature of this authorization:

_____ _____
Signature of Patient/Responsible Party Relationship to Patient

_____ _____
Employee Signature Date

This information has been disclosed to you from records whose confidentiality is protected by Pennsylvania law. Pennsylvania law prohibits you from making any further disclosures of this information unless further disclosure is expressly permitted by the written authorization of the person to whom it pertains or is otherwise permitted by law. A general authorization for the release of medical or other information is not sufficient for this purpose.