

**DAVENSHIRE MEDICAL CENTER**

3740 Carlisle Road, Dover, PA 17315

Phone # 717-292-3168 • Fax # 717-292-3479 • www.DavenshireMC.com

**AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS**

Patient's Full Name: \_\_\_\_\_ Maiden Name/Alias: \_\_\_\_\_

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 the entity listed/selected below.

Please write the Physician/Facility Name, Address, Phone, &/or Fax #:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**3) THIS SECTION IS ONLY FOR USE OF RECORDS TO BE RECEIVED:**

By selecting these facilities, I hereby authorize Davenshire Medical Center to **obtain** available records.

Which of the following facilities have you used in the past? **Select all that apply**

- Wellspan Health
- UPMC Health
- Penn State Hershey
- Penn State Holy Spirit
- OSS Health
- Johns Hopkins
- Lancaster General/Penn Medicine

**4) Please release the following records within the service date years from \_\_\_\_\_ to \_\_\_\_\_.**

**\*\* If service date range is not specified, a minimum of the last two years' worth of records will be released/obtained.**

**Please select all that apply:**

- All Medical Health Records
- MVA or Workers Comp notes & reports
- Other, as specified: \_\_\_\_\_

**5) 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

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 (valid for one year from this 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.