Susan Sander, MD
Nicole Geracimos, MD
Pamela Barnes, CRNP
Melissa Taylor, CRNP

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

_____ _____
PATIENT'S NAME (*Please Print*) **DATE OF BIRTH**

_____ _____
ADDRESS (*Street, City, State, and Zip Code*) **PHONE (*Area Code and Number*)**

I, the undersigned, authorize the disclosure/use of the above named patient's health information.

From: _____
FULL NAME OF INDIVIDUAL OR ENTITY

_____
ADDRESS (*Street, City, State, and Zip Code*)

_____ _____
PHONE (*Area Code and Number*) **FAX (*Area Code and Number*)**

To: **Tohickon Internal Medicine, LLC**
1456 Ferry Road, Suite 400
Doylestown, Pennsylvania 18901
267-880-6350 (Phone) 267-880-6592 (Fax)

I request that the following health information be disclosed to/used by Tohickon Internal Medicine, LLC:
Please check all that apply.

____ Complete Medical Record	____ Progress/Visit Notes	____ Imaging Reports
____ Complete Billing Record	____ Consultation Reports	____ Laboratory Results
____ History and Physical Exams	____ Operative/Procedure Reports	____ Pathology Results

____ Other (Please specify): _____

Covering the period of health care from: _____ **to:** _____
DATE **DATE**

I authorize Tohickon Internal Medicine, LLC to be disclosed/use information relating to psychiatric condition(s), alcohol and/or drug abuse, and HIV/AIDS in accordance with Federal confidentiality rules.

_____ _____
SIGNATURE OF PATIENT / LEGAL GUARDIAN / LEGAL REPRESENTATIVE **DATE**

_____ _____
NAME OF LEGAL GUARDIAN / LEGAL REPRESENTATIVE (*Please Print*) **RELATIONSHIP TO PATIENT**

Please attempt to limit faxed information to less than 20 pages.