RECORDS RELEASE

Records Requested from:

Please forward the indicated sections of my Medical Records To:

BuxMont Medical Associates, P.C.
The Health and Wellness Center
847 Easton Road, Suite 2500
Warrington, PA 18976

Required sections:

- ❑ **Office/Progress Notes** **All or _____ years**
- ❑ **Labs** **All or _____ years**
- ❑ **EKGs** **All or _____ years**
- ❑ **Specialist Notes** **All or _____ years**

Purpose of Release:

- ❑ **Continuity of Care**
- ❑ **Other (specify reason) _____**

Patient's Name:	
Address	
Date of Birth	

This authorization designates BUXMONT MEDICAL ASSOCIATES, P.C. to release any and all information pertaining to medical history and treatment INCLUDING mental health/psychiatric care, drug and alcohol abuse, HIV-related information and sexual abuse/counseling information.

It is my intent that information furnished is prohibited for any purpose other than that stated above and that the recipient is prohibited from disclosing this information to any other party to whom disclosure is not necessary or required for the purpose stated above.

I further direct that only information prior to the date of my signature below be honored that this consent is valid for 90 days but is subject to revocation (in writing) at any time except to the extent that the person who is to make the disclosure has already acted in reliance on it. A photocopy of this authorization is granted the same authority as the original.

I further hereby release BUXMONT MEDICAL ASSOCIATES, P.C. from all legal responsibility and/or liability that may arise from the release of such records as specified above.

_____ _____

Patient (parent or guardian if under 18) Date