General Medical Records Release and Authorization for Use or Disclosure of Protected Health Information

Please complete the following information:

Patient Name: _____

Address: _____

_____

Phone: _____ Date of Birth:_____/_____/_____

I authorize Todd A. Hoover, MD, LLC: _____ to disclose/release the following information* (check all applicable):

- ☐ All records for past _____ years / ____ All years
- ☐ Office notes for past _____ years
- ☐ Lab and X-ray reports for past _____ years
- ☐ Other Consultations for past ____ years
- ☐ Original Intake Form
- ☐ Vaccination Records

***Note:** If these records contain any information from previous providers or information about HIV/AIDS status, cancer diagnosis, drug/alcohol abuse, or sexually transmitted disease, you are hereby authorizing disclosure of this information.*

Please send the records listed above to:

Name: _____

Address: _____

City: _____ State____ Zip: _____

The information is being disclosed / sent at my request. I understand that I will be charged a fee. I understand that after the custodian of records discloses my health information, it may no longer be protected by federal privacy laws. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment; receive payment; or eligibility for benefits unless allowed by law. By signing below I represent and warrant that I have authority to sign this document and authorize the use or disclosure of protected health information and that there are no claims or orders pending or in effect that would prohibit, limit, or otherwise restrict my ability to authorize the use or disclosure of this protected health information.

_____ _____

Signature of patient (or patient's personal representative) Date

_____ _____

Printed name of patient or representative Representative's authority to sign for patient *(i.e. parent, guardian, power of attorney, executor)*

You have the right to revoke this authorization, except to the extent the custodian of records has relied on it, by sending your written request to the Todd A. Hoover, MD, LLC PO Box 486 Narberth, PA 19072.

Please send completed form to:

Todd A. Hoover, MD, LLC
PO Box 486
Narberth, PA 19072

A card will be sent to your address detailing the cost for record copying / transfer. No records will be sent until payment is received.