JEFFERSON INTERNAL MEDICINE
David S. Lilienthal, MD
Faith McGrady, PA-C ~ Ellie Meehl, PA-C ~ Erika Wisler, CRNP ~ Gina Hudak, PA-C
575 Coal Valley Road, Suite 374 ~ Clairton, PA 15025
(412) 469-7744 ~ Fax (412) 469-7766

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

Patient Name: _____

Address: _____

_____

Date of Birth: _____

I hereby authorize: _____

_____

_____

To release my records to:

David S. Lilienthal, MD
Jefferson Internal Medicine
575 Coal Valley Road, Suite 374; Clairton, PA 15025
(412) 469-7744 ~ Fax (412) 469-7766

For the purpose of: _____

Please disclose the following information (please check all that apply) from my health records for the period of

_____ to _____.

___ Complete Health Record(s)	___Discharge Summary	___ AIDS and/or HIV
___ History & Physical Examination	___Consultation Reports	___ Mental Health/Psychiatric Care
___ Progress Notes, Laboratory Reports	___X-ray Reports	___ Alcohol and/or Drug Abuse
___ Other: _____		

This statement must be signed and dated and may be revoked at any time, except to the extend action has been taken prior to any expressed action to revoke this statement. The validity of this authorization will extend 30 days from the date of signature. If no action has been taken to process this statement within that time frame, an automatic expiration will be in effect. I understand the nature of this release and freely give my consent.

_____ _____
Authorized Signature Date

_____ _____
Witness Signature Date

The above name patient is unable to provide a signature. He/She understands the nature of this release and freely gives his/her consent.

_____ _____
Witness Signature Date