LOFTS MEDICAL ASSOCIATES, P.C

170 Middletown Blvd., Suite 101, Langhorne, PA 19047
Phone: 215-757-8100 Fax: 215-757-7358

HIPAA AUTHORIZATION FORM FOR RELEASE OF MEDICAL RECORD INFORMATION

In the State of Pennsylvania, the physician who creates the patient's medical records is the owner of those records. Current Pennsylvania Law states that a PHOTOCOPY of the medical records may be released to the patient or the patient's representative upon proper request within a reasonable period of time. "Proper Request" means a request in writing, and the form below may be used for that purpose. Please note that the law allows the physician a "Reasonable Period of Time" to comply with your request. It also permits the office to charge a Reasonable Fee for preparing the copy.

Patient Name_____ Date of Birth_____

Address_____ City_____ State_____ Zip_____

Telephone_____ Cell Phone_____

I hereby authorize **Lofts Medical Associates, PC** to use or disclose the protected health information for the above named patient as described below.

PLEASE RELEASE RECORDS FROM:

Doctor Name:_____

Phone

DO NOT DOUBLE SIDE RECORDS WHEN SENDING

NOTICE: We do NOT accept CDs.

Number:_____

Address:_____

My purpose for/intended use of this information is:

_____ Transfer of Care
_____ Personal Use
_____ Legal
_____ Insurance benefits
_____ Other:_____

Dates of Service

_____ All Medical Records
_____ Healthcare Information related to the following treatment, dates of treatments, or condition:_____

_____

_____

Information about alcohol/substance abuse, HIV/AIDS or mental health issues, including ADD and ADHD.

_____ YES, disclose this information
_____ NO, do NOT disclose this information

I understand that the information used or disclosed may be subject to re-disclosure by the person or facility receiving it and then would no longer be protected by federal privacy regulations.

I may revoke this authorization by notifying **Lofts Medical Associates, PC** in writing of my desire to revoke. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions. I understand that the medical provider to whom this authorization is furnished my not condition its treatment of the above named patient on whether or not I sign the authorization.

Signature of Patient **Date** **Date of Birth**

Signature of Representative Date Relationship or Authority

This authorization will expire in one (1) year after the date on this request