

Health Services  
Phone: 717.872.3250  
Fax: 717.871.2243

**Request for Release of Medical Information**

I hereby authorize:

Name/Facility: \_\_\_\_\_

Address: \_\_\_\_\_

Phone/Fax#: \_\_\_\_\_

To release to:

Name/Facility: \_\_\_\_\_

Address: \_\_\_\_\_

Phone/Fax#: \_\_\_\_\_

Any and all information regarding my physical condition and treatment rendered. I authorize release of this information to the above individuals for the purpose of continuing care, and allow them or any other physicians appointed by them to examine this information.

I authorize the release of the following (please initial if applies):

\_\_\_\_\_ Psychiatric/psychotherapy records

\_\_\_\_\_ Sexual abuse records

\_\_\_\_\_ Drug/alcohol treatment records

\_\_\_\_\_ AIDS/HIV related medical records

Specific information requested: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Address: \_\_\_\_\_

Witness signature: \_\_\_\_\_

This medical release expires on \_\_\_\_\_  
(Date)

This information is confidential; if you have received this request in error please notify us immediately.