Crowley Medical Associates

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

Patients Name: ________________________________________________ DOB: _________________
Address: ______________________________________________________________________________
Phone Number: __________________________

**Requesting Medical Records from:**

Physician name: ________________________________
Address: ___________________________________________________________________________
Phone Number: __________________ Fax Number: ________________________

Covering the period of treatment dates from ___ / __/ ___ to __ / __ / ___

I request my PHI to be released to:
Crowley Medical Associates
Kurt R. Crowley M.D.
325 Central Avenue, STE 102
Malvern, PA 19355
Phone: (610) 578-0155 Fax: (610) 578-0156

- Please release my records directly to me via (circle one): mail, email, in-person

**I authorize the following PHI to be released from my medical records:**

___Discharge Summary
___Discharge Instructions
___History and Physical
___Consultations
___Operative Report
___ ER Record
___ X-Ray Reports
___Lab Reports
___EKG/ECG Tests
___Physical Therapy Notes
___ Progress Notes
___Medication Records
___ Doctor's Orders
___Nurse's Notes

Other (please specify): ______________________________________________________________

**I authorize the release of sensitive health information by checking "Yes" below:**
Substance Use Disorder: YES or NO
Mental Health: YES or NO
AIDS/HIV: YES or NO

Delivery Method excepted by Crowley Medical Associates
US Mail (Paper)
CD
USB
Fax

**AUTHORIZATION**

My authorization will automatically expire one hundred eighty (180) days after the date of signature. I may revoke this authorization at any time but must do so in writing, and the revocation will not apply to information that has already been released. Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by relevant federal and/or

state law. My refusal to sign this authorization will not affect my ability to receive treatment. By signing this form, I understand that I am authorizing my medical information to be released as described above.

Signature of Patient or Personal Representative: ________________________________________
Print Name: ______________________________________________
Relationship of Personal Representative to Patient: __________________________________
Date: _______________________

If Authorization is signed by someone other than the patient, please state the reason:
_________________________________________________________________________________________
_________________________________________________________________________________________
_________________________________________________________________________________________
_________________________________________________________________________________________
_________________________________________________________________________________________

Signature of Witness for Verbal Consent: ___________________________________________
Print Name: ______________________________________
Date: ______________