Quality Family Physicians, PA
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AUTHORIZATION FOR FUTURE RELEASE OF MEDICAL RECORDS

I, the undersigned, hereby authorize the full release of medical records directly to Quality Family Physicians, PA from the following list of sources effective as of today and for any future dates on an as-needed basis so long as I am still under the care of Quality Family Physicians, PA, and the records will assist with my medical care.

- Any and all designated specialists or sub-specialists, both current and prior.
- Inpatient medical records from any and all hospitals, nursing home facilities and extended care facilities.
- Emergency departments from any and all hospitals or medical aid units.
- Any and all laboratories.
- Any and all radiology facilities.
- Any and all rehab, physical therapy and chiropractic facilities.

TO BE COMPLETED BY THE OFFICE

Attention:		
Name of Doctor or Facility:		
Address:		
City:	State:	Zip:
Office Phone:	Fax:	

I acknowledge that this form may be duplicated as needed if addressing to multiple facilities or for any future unforeseen medical record requests. Please accept my photocopied signature as valid authorization.

X_____
Print Patient Name

X_____
Patient Date of Birth

X_____
Patient Signature

_____

(**IF** under 18 years of age, signed by parent/guardian)