David A. Popper, M.D., F.A.C.G.
Kenneth S. Breslin, M.D., F.A.C.G.
Steven A. Rafelson, M.D., F.A.C.G.
J. Matthew Bohning, M.D.
Jyothi Mekapati, M.D.
Kimberly W. Bidwell, C.R.N.P

AUTHORIZATION TO RELEASE MEDICAL RECORDS

I,_____, authorize any physician, nurse, or other health care professional who has attended me, or any hospital at which I have been confined to furnish to_____, or an authorized representative, any and all information that may be requested regarding my physical or mental condition and treatment rendered therefore and, if necessary, to allow them to examine any x-ray films taken of me or records regarding my physical or mental condition or treatment. In addition, I also authorize the release of psychiatric/psychotherapy records, mental health records and drug and alcohol use information or treatment records under the same terms and conditions. A photocopy/fax copy of this instrument may be used instead of the original.

_____ _____
WITNESS SIGNATURE

_____
DATE

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Tele. (215) 321-7221 · Fax (215) 321-9109