Persila V. Mertz, MD, PC

115 E. Main St

Ephrata, PA 17522

Authorization of the Release of Medical Records for Use or Disclosure of Protected Health Information

Patient Name: _____

SSN: _____ Date of Birth: _____/_____/_____

I authorize _____to release the medical records of:

Name of Facility/Practice

_____ to _____.

Name of Patient *Name of Facility/Practice*

Please include the following records:

- ○ All Records
- ○ Laboratory/Pathology Records
- ○ Pharmacy/Prescription Records
- ○ Radiology Records
- ○ Other _____

Please send the records listed above to:

Name: _____ Phone: _____

Address: _____

_____ Fax: _____

Reason for release of records:

- ○ At my request (only patient may check this option)
- ○ Coordination of care
- ○ Other _____

I understand that this authorization is voluntary and I will not be denied medical treatment if I refuse to authorize the release of my medical records. I also understand that I may at any time revoke this authorization by sending a written request to the office of Persila V. Mertz, M.D., P.C. By signing below, I acknowledge I am authorizing the release of any information from previous medical records that may include any information or diagnosis of HIV/AIDS status, drug/alcohol abuse, cancer, or a sexually transmitted disease.

_____ _____

Signature of Patient or Guardian *Date*