

# Dallas Family Practice, LLC

16 Church Street  
Dallas, PA 18612  
(570) 675-2111 Fax (570) 675-6545

## CONSENT FOR RELEASE OF INFORMATION

- General Authorization
- Specific Request of Drug and Alcohol Abuse Patient
- Specific Request of HIV Diagnostic Testing Patient
- Specific Request of Psychiatric Patient

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

I hereby request and authorize Dallas Family Practice, LLC to release information from the medical records of:

\_\_\_\_\_  
Patient's Name

\_\_\_\_\_  
Date of Birth

### THE INFORMATION TO BE RELEASED IS:

\_\_\_ All Medical Information

\_\_\_ Hospital Notes

\_\_\_ Laboratory

\_\_\_ X-Rays

\_\_\_ Office Notes

\_\_\_ Specific Information: \_\_\_\_\_

### THE INFORMATION IS TO BE RELEASED TO THE FOLLOWING:

Name: \_\_\_\_\_

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

- I have read and understand the above consent and hereby release Dallas Family Practice, LLC and it's employees from any and all legal responsibility in connection with this act.
- I understand this consent is subject to written revocation only, at any time except to the extent that the person who is to make the disclosure has already acted in reliance on it.
- This consent will expire in 60 days from the date of signature if not revoked earlier.

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date of Signature (Patient)

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Signature of Responsible Party

\_\_\_\_\_  
Date of Signature (Witness)

\_\_\_\_\_  
Date of Signature (Responsible Party)