Authorization for Release of Health Information

Patient Name:_____

Birthdate:_____

Address:_____

Send Copies to: Dr Damian Horner, D.O., Family Practice, LLC.
10 Plumber Street, Warren, PA 16365
Phone: 814-723-2779
Fax: 814-723-1518

This authorization permits the disclosure of important medical records pertaining to the individual named above. We are requesting the last 48 months of medical records, unless otherwise noted. Please fax if records are 100 pages or less. Otherwise please mail.

Please circle the specific information to be released:

All Records	Laboratory Reports	Radiology Reports	EKG Reports
Hospital Reports	Consultation Reports	Operative Reports	Emergency Room
Pathology Reports	Discharge Summary	Colonoscopies	Medication Lists

Records are requested for the purpose of (Please Circle one) Continuing Care Insurance Other
Transfer of Care Legal Use Personal Use

I understand and authorize the release of medical information to Dr. Damian T. Horner, D.O.Family Practice, LLC. I understand that I have the right to revoke this authorization at anytime by sending a written request to the entity/person I authorized above to release the information.

Signature of Patient:_____

Date:_____

Previous Physician:_____

This authorization is effective for 90 days from the date of signature, unless otherwise specified below.