Authorization for Release of Medical Records

(Pennsylvania HIPAA-Compliant Form)

Patient Information

Full Name: _____

Date of Birth: _____

Address: _____

Phone Number: _____

Provider/Facility Releasing Information

Name: _Amy Fitzsimmons, M.D.

Address:44 Second Street Pike Suite 200, Southampton, Pa. 18966

Phone: _215-322-7550 Fax: 215-322-7117

Recipient of Records

Name/Facility: _____

Address: _____

Phone: _____ Fax: _____

Purpose of Disclosure (check one or more):

☐ Medical Care

☐ Legal

☐ Insurance

☐ Personal

Information to be Disclosed (check all that apply):

☐ Office Visit Notes

☐ Lab Reports

☐ X-Ray/Imaging Reports

Please turn over

Authorization Details

This authorization is valid for one year unless otherwise revoked.

I understand that I may revoke this authorization at any time in writing.

I understand that once information is released, it may no longer be protected by federal privacy regulations.

Signature of Patient or Legal Representative: _____

Date: _____

Relationship to Patient (if applicable): _____