Penn Medicine

Attention Medical Records

Patient Name:		DOB:
Address	City/State/Zip Code	Telephone Number

A. Records Released from:

Name (Institution, Physician...)	
Street Address	
City	
Phone #	Fax #

B. Records Released to:
Attention:
Penn Medicine at Radnor
145 King of Prussia Rd
Suite 205 South
Radnor, PA 19087
Phone: 610-902-4858 Fax: 610-902-5609 or 610-902-2304

C. Information to be Released:

☐ Complete copy of all records ☐ Discharge Summary ☐ Clinic Notes

☐ Lab Results ☐ Radiology Reports/Films ☐ Pathology slides

☐ Other (Specify):

For the Following Dates: _____

D. Purpose for Release of Information: Continuation of Care

E. This authorization will remain in effect until this request is processed unless you specify this authorization will be effective for an additional time period. Written consent is necessary to revoke this request.

F. I authorize release of my medical records in accordance with the specification listed above. I understand that I have a right to inspect and receive a copy of the disclosed material. A photocopy of this consent shall be valid as the original.

Signature: _____ Date: _____

Printed Name: _____