Request for release of medical records

Patient name: ____

Date of Birth: ________________________ Medical record number, if known: ________________

Address: ____

Apt __________________City______________________________________State_____________

Last 4 digits of social security number: _____________________

Records will be coming FROM (please check):	*Please release records TO:*
___Urban Health Initiatives c/o Spectrum Healthcare Systems 1415 N. Broad St., #2 Philadelphia, PA 19122 ___ other:___________________________ _______________________________ _______________________________ _______________________________	Eileen K. Carpenter, MD Spruce Internal Medicine 800 Walnut St., 16th Floor Philadelphia, PA 19107

Please release copies of my medical record, including paper and electronic records, for all dates of service. The purpose of the release is because I am transferring my primary medical care to Spruce Internal Medicine. **PLEASE CHECK WHETHER THE FOLLOWING INFORMATION MAY BE INCLUDED:**

[__ include ___ exclude] records related to mental health/substance abuse/alcohol

[__ include ___ exclude] records related to STD/HIV

* Signature:_____________________________________

(patient or person acting for patient)

Date signed: _______________________ This authorization will expire one year from the date signed.

Relationship to patient:
___ I am signing for myself
___ I am signing for my _____________________________________ (relationship)

* Witness signature: ____