Penn Medicine

AUTHORIZATION TO RELEASE MEDICAL RECORDS

Please send my medical records from:

Urban Health Initiatives, c/o Spectrum Healthcare Systems
1415 N Broad St.
Philadelphia, PA 19122
Phone: 215-235-7944 Fax: 215-235-3361

Disclosed Information: (please check all items to be released)

☒ Entire Record ☐ Abstract
☐ Discharge Summary ☐ Operative Report ☐ Lab Reports ☐ Radiology Images
☐ Discharge Instructions ☐ ER Record ☐ EKG/ECG Tests ☐ Medication Records
☐ History & Physical ☐ X-Ray Reports ☐ Progress Notes ☐ Physician Orders
☐ Consultations ☒ Other: Please send as electronic copy

Covering my period of care (list applicable dates): ___all dates of care_____

Special Records:

I understand that information related to my diagnosis or treatment for AIDS/HIV, psychiatric care and treatment, treatment for drug and alcohol abuse may be released as part of my health information. I wish the following information ***excluded*** from my records release:

☐ HIV/AIDS ☐ Drug Abuse ☐ Alcohol Abuse ☐ Mental Health ☐ Sexually Transmitted Diseases

Please mail my records to **PMWS Internal Medicine – Medical Records Section**
800 Walnut Street, 16th Floor
Philadelphia, PA 19107

Gaining practice: ☐ Delancey Medical Associates ☒ Spruce Internal Medicine

Patient Information:

Name: _____

Address: _____

_____

Phone: _____ Date of Birth: _____

_____ _____

*Patient or Guardian **Signature*** *Date*