# Record Release Authorization:

*PLEASE PRINT*

NAME: _____ DOB: _____ / _____ / _____

ADDRESS: _____ PHONE #: _____

I, _____, hereby request and authorize the release of my complete medical record in your possession concerning my illnesses and/or treatments.

## Please Release my Records ***FROM***:

Office: _____ Phone #: _____

Doctor name/Practice name

_____

Address

_____

City State Zip

## And Forward ***TO***:

_____ Family Practice of Jeffersonville, LLC / Dr. Scott Yarmark

190 West Germantown Pike, Suite 155

East Norriton, PA 19401-1383

Phone: 610-277-9040 Fax: 610-277-7890

_____ Jeffersonville Family and Geriatric Medicine, LLC / Dr. William Dickerman

190 West Germantown Pike, Suite 155

East Norriton, PA 19401-1383

Phone: 610-277-9040 Fax: 610-277-7890

******PLEASE DO NOT FAX RECORDS OVER 20 PAGES******

******If sending records by disc, we ONLY accept XML files******

Signature of Patient *or* Authorized Representative: _____

Date: _____ / _____ / _____