ZABRECKY
INSTITUTE of Biomedicine

Authorization to Release Information

Patient's Name _____
Last First Middle Initial

Address_____
Street City State

Home Phone_____ DOB_____ Patient #_____

I,_____, authorize the release of medical information from my medical records to:

- ☐ Dr. George P. Zabrecky, Dr. Aggie Hewitt, and Diane M. Coughlan, CRNP
- ☐ Myself: _____
- ☐ Other: _____
  Please specify name or organization where records are being sent
- ☐ My Insurance Company:_____

For the purpose of review/examination, I further authorize you to provide such copies thereof as may be requested. The foregoing is subject to such limitations as indicated below:

- ☐ Entire Record
- ☐ Specific Information:_____
- ☐ Old Records from Previous Physicians:_____

I give special permission to release all information regarding: [initial on applicable line(s) below]

_____Substance Abuse _____ Psychiatric/Mental Health Information _____ HIV Information

Reason for request: _____

I understand that I may revoke this consent at any time except to the extent that action has been taken in reliance thereon.

Signed _____ Date_____
If not patient, state relationship

Witness_____ Date_____

789 E. Lancaster Ave. | Suite 230 | Villanova, PA 19085 office: 610-616-2500 fax: 484-685-7890
www.ZabreckyInstitute.com