RECORDS RELEASE AUTHORITY

TO:______________________________ I,______________________________

Patient's Name

hereby request that you release the following records and data pertinent to your treatment of me:

from____________________________to______________________________

on to:

Lucy E. Hornstein, MD
Valley Forge Family Practice
1288 Valley Forge Road, Suite 83
Phoenixville, PA 19460
Telephone: (610) 983-9299

Types of records requested (e.g. lab tests, specific records, summary of records etc.)______________

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Pick one: ☐ Fax ☐ Paper Copy ☐ USPS ☐ Via encrypted email

☐ Via regular (unencrypted) email- I understand that there are possible risks due to the insecure nature of unencrypted email.

Patient's Date of Birth	Signature of Patient, Parent, Guardian, or Personal Representative
Witness	Please print name signed above
Date	Relationship to Patient

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