CENTRAL BUCKS FAMILY PRACTICE, P.C.

BOARD CERTIFIED
FAMILY PRACTICE

BAILIWICK OFFICE CAMPUS
SUITE 41
252 WEST SWAMP ROAD
DOYLESTOWN, PA 18901
215-348-1706

COMMONWYDDS OFFICE CAMPUS
SUITE F1
2370 YORK ROAD
JAMISON, PA 18929
215-343-5444

DENNIS H. TAFFLIN., D.O., A.O.B.F.P.
DAVID A. SMITH., M.D., A.B.F.M.
SARAH E. ROBIN., D.O., A.B.F.M.
PHILIP R. TREIMAN., M.D., A.B.F.M.
ROBERT G. LEWCUN., D.O., A.O.B.F.P
JEFFREY T. LAPHEN., M.D., A.B.F.M.
DEBORAH S. WRIGHT.,M.D., A.B.F.M.
BRENNA K. DOBSON., P.A.-C.
FRANCINE SCHWARTZ., C.R.N.P.

Authorization to
Release ☐
Obtain ☐
Medical Information

Patient Name: _____
Date of Birth: _____
Address: _____
_____
Phone: _____

I herby authorize Central Bucks Family Practice, PC to Release / Obtain Medical Information From:

Facility: _____
Physician: _____
Address: _____
_____
Phone: _____
Fax: _____

I hereby request my medical records from _____ to _____ be released.

I authorize the release of any and all information regarding my physical or mental condition and treatment rendered. In addition, I also authorized the release of psychiatric/psychotherapy records, mental health records, and drug and alcohol treatment information under the same terms and conditions.

_____ _____
Signature (Required) **Date**

I authorize the release of all medical records, charts, notes, x-rays and any other information relating to my general physical condition, including confidential HIV-related information.

_____ _____
Signature (Required) **Date**