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.
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BRENNA K. DOBSON., P.A.-C.
FRANCINE SCHWARTZ., C.R.N.P.
HEATHER HANSBARGER., P.A.-C.

Authorization to
Release ☐
Obtain ☐
Medical Information

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

I hereby 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**