CENTRAL BUCKS FAMILY PRACTICE, P.C.

BOARD CERTIFIED
FAMILY PRACTICE

BAILIWICK OFFICE CAMPUS
SUITE 41
252 WEST SWAMP ROAD
DOYLESTOWN, PA 18901
O: 215-348-1706
F: 215-348-0321

COMMONWYDDS OFFICE CAMPUS
SUITE F1
2370 YORK ROAD
JAMISON, PA 18929
O: 215-343-5444
F: 215-491-7099

DENNIS H. TAFFLIN., D.O., EMERITUS
DAVID A. SMITH., M.D., A.B.F.M.
PHILIP R. TREIMAN., M.D., A.B.F.M.
JEFFREY T. LAPHEN., M.D., A.B.F.M
ROBERT G. LEWCUN., D.O., A.O.B.F.P
RACHEL A. POLISH, D.O. A.O.B.F.P.
A. NATHAN GORHAM, D.O., A.B.F.M.
BRENNA K. DOBSON., P.A.-C.
HEATHER A. HANSBARGER., P.A.-C.
COLLEEN F. MURPHY, P.A.-C.
REBECCA S. GORDON P.A.-C.

Authorization for Transfer of Medical Information for:

NAME: ______________________________

DATE OF BIRTH: ______________________________

ADDRESS: ______________________________

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PHONE: ______________________________

I hereby authorize Central Bucks Family Practice, PC
☐ to Release my medical records to the following
☐ to Obtain Medical Information From:

FACILITY: ______________________________

PHYSICIAN: ______________________________

ADDRESS: ______________________________

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PHONE: ______________________________ FAX: ______________________________

I hereby request my medical records from
______________________ to ____________________ be released.

I authorize the exchange 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**