# AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

**Specific information to be released:**

_____

_____

[] I hereby authorize the following person(s) and/or organization(s) to release the above information to:

Dr. Donald A. Rauh M.D., Ph.D.
306 Floral Vale Boulevard
Yardley, PA 19067-5525
(215) 860-6101

*AND/OR*

[] I hereby authorize Dr. Donald A. Rauh to release the above information to the following person(s) and/or organization(s):

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

I understand that this information is not to be re-released to any person or facility except as provided by law. This release will continue until termination of treatment unless otherwise specified: _____.

I understand that I may revoke this release of information at any time. I understand, however, that any release which was made prior to my revocation and which was made in reliance upon this authorization shall not constitute a breach of my right to confidentiality. Unless I revoke this authorization prior to such time, this authorization to release information shall expire when the desired information is sent.

To the extent that my medical record contains information regarding alcohol or drug treatment that is protected by Federal Regulation 42 CFR, Part 2, I authorize disclosure of such information.

X_____ _____

Signature of Patient (if 18 or older);
Or Parent (if patient under 18);
Or Legal Guardian; or Health Care Agent

Signature of Witness

X_____ X__/__/__ _____ __/__/__

Printed Name of Patient or Authorized Person (if other than Dr. Rauh)

Date

Printed Name of Witness

Date

X__/__/__ _____ _____

Patient's Date of Birth

Title of Authorized Person (if applicable)