



FORM 5

**PHILADELPHIA HEALTH ASSOCIATES
ADULT MEDICINE, P.C.**

www.phaadultmedicine.com

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Authorization for Release of Medical Records to PHA-Adult Medicine

Note: For the release of mental health, drug and alcohol records, and/or HIV/AIDS, please complete CONSENT FOR RELEASE OF MEDICAL RECORDS with SENSITIVE INFORMATION

I hereby authorize _____,
(Name of Provider and /or Agency)
its agents and/or servants, and participating providers to release to:

**Philadelphia Health Associates – Adult Medicine, P.C.
ATTN: Medical Records**

the following information from the health records of:

Patient's Name _____ Date of Birth _____
Address _____
Medical Record Number (if known) _____ Telephone Number _____
Primary Care Physician _____
for the purpose of: _____

This information is to cover the period(s):

From: _____ to: _____
From: _____ to: _____

and should include the following information (please check):

- Progress Notes/Health History
- Consultations
- Lab Tests
- Diagnostic Reports
- other (please specify) _____

I voluntarily consent to the release of the information requested. I understand that I have the right to inspect and copy the information to be disclosed and I may withdraw this authorization at any time, except to the extent that action has been taken based on this authorization. I understand that this authorization shall expire, without my express revocation, sixty (60) days from the date written below. I hereby agree to hold Philadelphia Health Associates ó Adult Medicine, P.C., its agents, employers, and participating providers free and harmless from any actions against it or them for alleged invasion of privacy, libel, slander, or defamation arising in connection with disclosure of such information.

Signed _____ Date _____
(Patient)

OR _____ Date _____
(Legal Representative and Relationship to Patient)