Zaccagnini Medical Associates

MEDICAL RECORDS RELEASE FORM

This form is to be completed by the patient who is requesting his/her medical records be released. Upon completion the patient is to sign the form and submit to the entity from whom the records are being requested.

RECORDS RELATED TO:

_____ Patient's Full Name – Please Print

_____ Patient's Date of Birth

_____ Street Address

_____ Social Security Number

_____ City, State and Zip Code

_____ Beginning Date

_____ Contact Phone Number

_____ Date of Request

RECORDS TO BE RELEASED: (Patient to check each type of record requested)

If ever hospitalized, most recent: History and Physical Discharge Summary

Most recent copies of:

Mammogram Colonoscopy Operative Reports Progress Reports
Laboratory Reports Radiology Reports EKG Cardiac Catherization Report
Pathology Reports Emergency Room Reports Other _____

I do _____ I do **NOT** _____, authorize release of information related to AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) infection, psychiatric care and/or psychological assessment, and treatment for alcohol and/or drug abuse.

RELEASE INFORMATION TO:

Zaccagnini Medical Associates
ATTN: MEDICAL RECORDS
326 Frye Farm Road
Greensburg, PA 15601
P: 724-205-6185
F: 724-691-0315

I hereby authorize disclosure of the above noted health information from _____ to Zaccagnini Medical Associates. I understand that I may cancel this request with written notification but that will not affect any information released prior to notification of cancellation.

_____ Signature of Patient, Guardian, or Personal Representative of Patient's Estate

_____ Date