Family Professional Center
60 Terence Drive – Suite 101
Pittsburgh, PA 15236
Phone: 412-653-4900 – Fax: 412-653-9969

Consent for Release of Medical Information
All Sections Must Be Complete

Patient Name: _____

Patient Address: _____

Date of Birth: _____ Phone Number: _____

I hereby request and authorize the following physician to release my information:

Name: _____ Phone: _____

Street: _____ City: _____Zip: _____

Release to:

Name: _____ Phone: _____

Street: _____ City: _____ Zip: _____

What Information to Send:

_____ A complete photocopy of the above mentioned patient's medical records. Including chart notes, diagnostic interpretations, and other information related to the general physical condition, including confidential HIV related information, and records related to mental health and drug or alcohol related conditions of this patient.

_____ Specifically Send: _____

The purpose of this release and disclosure is: _____

I understand that this consent can be revoked at any time except to the extent that disclosure made in good faith has already occurred in reliance of this consent. I further understand that this release is valid for 90 days from the date below. A photocopy of this document may be used instead of the original.

Patient Signature: _____ Date: _____

Parent/Guardian Signature: _____ Witness: _____