



1339 West 6th Street, Erie, PA 16505
Telephone 814-480-8170
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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

THIS AUTHORIZATION OR PHOTOCOPY HERE OF, AUTHORIZES

TO FURNISH ALL INFORMATION THEY MAY HAVE REGARDING MY (OUR) CONDITION(S) WHILE UNDER THEIR DOCTOR OBSERVATION OR TREATMENT. INCLUDING, BUT NOT LIMITED TO, HISTORY OBTAINED, RADIOLOGIST, LABORATORY AND PHYSICAL FINDINGS, DIAGNOSIS AND PROGNOSIS.

I UNDERSTAND THIS RELEASE WILL NOT RESTRICT THE DISCLOSURE OF INFORMATION PERTAINING TO DRUG OR ALCOHOL ABUSE, PSYCHIATRIC CONDITIONS, A BLOOD TEST FOR AIDS OR AN AIDS DIAGNOSIS AND TREATMENT.

PLEASE TRANSFER MY COMPLETE MEDICAL RECORDS TO:

GOOD HEALTH FAMILY MEDICINE
DR. MICHELE POLON
1339 W. 6TH STREET
ERIE, PA 16505

NAME OF PATIENT	DATE OF BIRTH
1.	
2.	
3.	
4.	
5.	
6.	

SIGNED: _____ DATE: _____