MEDICAL RELEASE FROM ROSENMAN & LEVENTHAL, PC

Phone 215-321-3500

Fax 215-321-7172

I, ____ authorize the

Patient's Name

release of my medical records from Rosenman & Leventhal, PC to

____

Physician or Facility Receiving Records

____

Address of Doctor or Facility Receiving Records

Patient Date of Birth: ________________

Patient Telelphone #: ________________

Please release the following:

____ Complete Medical Record
____ Biopsy Report(s)
____ Lab Report(s)
____ Consultation Report(s)
____ Medication/Allergies
____ Allergy Test/Treatment
____ Surgical Procedures

Dates of Service

from: ____ to: ________________

____ ________________

Patient Signature *date*

____ ________________

Witness *date*