AUTHORIZATION TO RELEASE MEDICAL RECORDS

Patient: _____ **S.S. #** _____
Date of Birth: _____ **Age:** _____ **Sex:** _____
Address: _____

This Authorization To Release Medical Records expires on: _____

Release Of Records FROM **Leader Heights Spine, Joint & Nerve Associates**

This is to verify that I, _____ have requested the release of my: ☐ Medical Records ☐ Treatment Notes ☐ _____ that are part of my file maintained by Leader Heights Spine, Joint & Nerve Associates located at 2595 South George Street, York, PA 17403.

☐ I am personally picking up these records.
☐ I am requesting that these records are forwarded.

The requested records are to be released to the following health care provider/facility:

_____
_____
_____

Release Of Records TO Leader Heights Spine, Joint & Nerve Associates

This is to verify that I, _____ have requested the release of my:

☐ Treatment Notes ☐ Medical Records
☐ X-Rays (films or CD) ☐ X-Ray Reports Area: _____
☐ MRI (films or CD) ☐ MRI Reports Area: _____
☐ CT (films or CD) ☐ CT Reports Area: _____
☐ Diagnostic Reports ☐ _____

that are part of my file maintained by:

_____
_____
_____
_____

☐ I am personally picking up these records.
☐ I am requesting that these records are forwarded to Leader Heights Healthcare.

The above noted records are to be released to:

Leader Heights Spine, Joint & Nerve Associates
2595 South George Street Suite 7 York, PA 17403
Phone: (717) 741-4848 Fax: (717) 650-6383

This transaction is done at my specific request.

SIGNATURE [DO NOT PRINT] _____

DATE _____