Medical Record Release Authorization

NU HouseCalls
Health care at your doorstep.

_____
Print Patient's Full Name

_____
Street Address

_____
City, State, Zip Code

_____
SSN

_____ _____
Phone *Birth Date*

I, _____ authorize _____
(Name of facility or physician)

To release
- ☐ All records
- ☐ Operative reports
- ☐ Pathology reports
- ☐ Lab and/or radiology reports
- ☐ Other _____

To: Nancy Urankar, M.D.
NU House Calls
Box 490
Coopersburg, PA 18036

☐ **I do**

☐ **I do not**

authorize release of information related to HIV/AIDS, psychiatric and/or psychological care, and/or alcohol/drug use or abuse.

This authorization is valid for 12 months from the date of signature, I understand that I may cancel this request with written notification but it will not affect any information released prior to notification of cancellation.

_____ _____ _____
Signature of patient/guardian *(If guardian – relationship to patient)* *Date*

_____ _____
Witness *Date*