



**Lehigh Family Medicine, LLC**  
**Kenneth Sharp, DO**  
Board Certified Family Medicine  
525 Iron St Suite B  
Lehigh, PA 18235

Phone: (610) 377-4181  
Fax: (610) 377-4185

## **AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION**

_____ Patient's full name	_____ Date of Birth (Mo/Day/Yr)
_____ Street Address	_____ Social Security Number
_____ City, State, Zip Code	_____ Home Phone

At the request of the individual above, Lehigh Family Medicine, LLC, Kenneth Sharp, DO, hereby authorizes

\_\_\_\_\_  
Name of Practice or Health Care Provider

\_\_\_\_\_  
Address

\_\_\_\_\_  
City State Zip

\_\_\_\_\_  
Health Care Provider Phone

\_\_\_\_\_  
Health Care Provider Fax

to release the following medical records:

- |   |  |   |  |
|---|--|---|--|
| <input type="checkbox"/> History and Physical | <input type="checkbox"/> Lab Reports       | <input type="checkbox"/> Complete Record  | <input type="checkbox"/> Discharge Summary |
| <input type="checkbox"/> Progress Notes       | <input type="checkbox"/> Radiology Reports | <input type="checkbox"/> Most Recent Note |  |
| <input type="checkbox"/> Operative Notes      | <input type="checkbox"/> Hospital Records  | <input type="checkbox"/> Other _____      |  |

### **INFORMATION RELEASE TO: Lehigh Family Medicine, LLC**

**Kenneth Sharp, DO**  
525 Iron St Suite B  
Lehigh, PA 18235

**(610) 377- 4181 (Phone)**  
**(610) 377- 4185 (Fax)**

### **PURPOSE OF DISCLOSURE:**

- Establish care     Continuity of Care     Other \_\_\_\_\_

*I understand that:*

- *I may refuse to sign this authorization. I understand that my refusal will not affect my ability to obtain treatment at Lehigh Family Medicine (LFM) unless (a) the only purpose of the treatment is to create health information for the disclosure listed above; or (b) if my treatment is related to participation in a research study for which this authorization is required.*
- *I may revoke this authorization at any time by submitting a written notice of revocation to LFM at the address listed above. The revocation will be effective upon LFM's receipt of my written notice, except that it will not have any effect on any action already taken by LFM in reliance on this authorization.*
- *Once LFM has disclosed my health information to the recipient, LFM cannot guarantee that the recipient will not re-disclose my health information to a third party.*

**This authorization**     **will automatically expire 90 days or**     **has no expiration date (please check one).**

\_\_\_\_\_  
Signature of Patient, Guardian or Personal Representative    Date \_\_\_\_\_

\_\_\_\_\_  
Practice Representative/Witness    Date \_\_\_\_\_