



First State Physicians

Physical Medicine & Rehabilitation Center

Kevin J. McDermott, D.C.

MEDICAL RECORDS RELEASE

Patient's Name: _____ Date of Birth: _____

I hereby authorize _____ to release all medical records or those concerning the dates of treatment on _____, to First State Physicians, located at 12 Fox Run Shopping Center, Bear, Delaware 19701. These are requested for the purpose of medical care.

***** PLEASE FAX RECORDS TO 302-836-6294*****

Documents Requested should include:

- **Discharge Summary**
- **History & Physical**
- **Operative Record**
- **Physical Progress Notes**
- **Diagnostic Tests**
- **Other Notes**

I understand that this request for release of information is effective for 120 days. This request may be revoked at any time, but is not retroactive for requests that have been complied within good faith. This authorization can be revoked by written request to an authorized representative of First State Physicians.

Patient Signature

Date: _____

Signature of Legal Representative/Relationship

Date: _____

Disclosure of specific information authorized for release is limited to the above mentioned recipient only. Federal regulations, 42 CFR Part 2, prohibit the re-disclosure of the enclosed information unless the content expressly permits further disclosure of the re-disclosure is otherwise permitted under regulations.