Frankford Avenue Family Practice

8846 Frankford Avenue
Philadelphia, PA. 19136
Ph: 215-332-8221
Fax: 215-332-2979

Patient Name: ____

Patient DOB: ______________________

I hereby request my medical records to be:

TRANSFERRED FROM: ______________________________________

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SEND RECORDS TO:

Frankford Avenue Family Practice, PC
8846 Frankford Avenue
Philadelphia, PA. 19136
Ph: 215-332-8221
Fax: 215-332-2979

The purpose of this release of information is to transfer my medical records to my new physician. Unless I direct otherwise, the party designated above will receive a copy of my complete medical records, including HIV status, drug or alcohol treatment, mental health information, and sexually transmitted disease treatment information.

Please list any exclusions:_______________________________________

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My Name: ____

Address: ____

Telephone Number: ____

Signature: ______________________________ Date: ______________