Lehigh Valley Family Practice
N.K Grover MD
1401 Fairmont Street
Whitehall, PA 18052

AUTHORIZATION FOR MEDICAL RECORD RELEASE

From Doctor (previous) _____ *Phone#*_____

I _____ Date of Birth _____

request that all of my medical record be transferred to Dr. N.K. Grover's office. I can be contacted at the following location, for any questions. Street Address _____

City _____ State _____ Zip _____ Phone# _____

ATTENTION PATIENT

Please be alerted that if any of the following (3) boxes are checked, it is with the intention of making you aware that your record(s) contains "PROTECTED" information related to these categories. Therefore, your signature next to the identified category acknowledges your awareness of this fact. (This information has been disclosed to you from records whose confidentiality is protected by Federal Law [42 CFR Part 1] and PA State Statutes [Title 55 P.W. 5100.32 and 5100.34 (a) and (b) and DAACA, 71 P.S. 1690.108 (b) and (c)])

I further understand that there is specific information within my records which is protected under the

- ☐ _____ Confidential Alcohol & Drug Abuse Patient information, 42 CFR Part II
- ☐ _____ PA Mental Health Procedure Act
- ☐ _____ Confidentiality of HIV- Related Information Act, PA Law Act 148.

I also understand that my record may contain:

- Drug and alcohol information, if drug and alcohol tests were ordered of treatment provided by my Physician
- Psychiatric or psychological treatment was given by my physician;
- HIV related information, if HIV related tests were ordered by a physician

_____ _____
Date Signature

_____ _____
Witness Name