Authorization to Release Medical Records to Lifecycle

Records Requested From: _____

Practice Name: _____

Practice Office Phone: _____ Practice Office Fax: _____

Please release my medical records pertaining to: _____

_____

Please include the following confidential treatment information (check all to be included):

☐ HIV/AIDS
☐ Drug Abuse
☐ Mental Health
☐ Sexually Transmitted Diseases
☐ Alcohol Abuse

(*Unless the above specific information is checked to be released, in most instances, it will be removed from the records being sent.)*

The following information is provided to help you locate the records which I wish to be released:

Client name (Please Print): _____

Phone number: _____

Address: _____

_____

_____

Date of Birth: _____ SSN:_____

Send Records To:

Lifecycle Wellness and Birth Center
918 County Line Road
Bryn Mawr, PA 19010
Phone: 610-525-6086 // Fax: 610-525-1846
Tax ID: 23-2080859

Signature: _____ Date:_____