PREMIER PERSONAL HEALTHCARE
CONCIERGE INTERNAL MEDICINE

www.WarshawMD.com

RELEASE OF MEDICAL RECORDS

CONSENT TO RELEASE and/or RECEIVE CONFIDENTIAL INFORMATION

I, _____DOB_____
Name

Hereby authorize: Premier Personal Healthcare, LLC
Joel D. Warshaw, MD, FACP
2000 Oxford Drive, Suite 440
Pittsburgh, PA 15102
Ph. 412.833.2233
Fax 412-833-2293

❑ to release to: ☑ to receive from:

_____
Physician's Name and Facility

_____
Address City State ZIP

_____
Phone Fax

The information indicated below regarding my medical care:

☑ Progress Notes
☑ History and Physical
☑ Discharge Summary
☑ Lab Results
☑ X-Ray Reports
☑ EKG/Cardiac Reports

❑ Other:

USES: Premier Personal Healthcare (PPH) and Joel Warshaw, M.D. may use the records and information to provide me with health care goods and services.

DURATION: This authorization will expire one year from the date below, unless otherwise noted.

RESTRICTIONS: I understand that PPH and Joel Warshaw, M.D. may not further use or disclose the medical records and information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

_____ _____
Patient Signature (or legal guardian) Printed Name

_____ _____
Witness Signature Date