



Dr. DEBORAH RAMANATHAN, M.D.

Patient Record Transfer

241 Juniper St.
Quakertown, PA 18951
Telephone: (215) 536-6000
Fax: (215) 536-6002

Patient Information		
Name:		
Address:		
City:	State:	Zip:
Soc. Sec. #:	DOB:	

Send Patient Records To:		
Name:		
Address:		
City:	State:	Zip:
Attn:		

ATTENTION PATIENT

*This information release is for the purpose of providing medical information relating to my identity, diagnosis, prognosis, or treatment I do not give permission for any other use or redisclosure of this information

*Please be alerted that, if any one of the following three (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.

*I further understand that there is specific documentation within my records which is protected under the:

Signature	✓	Act
	<input type="checkbox"/>	Confidential Alcohol & Drug Abuse Patient Information, 42 C.F.R., Part II
	<input type="checkbox"/>	PA Mental Health Procedure Act
	<input type="checkbox"/>	Confidentiality of HIV-Related Information Act, PA Law Act 148

I also understand that my record may contain:

- 1- Drug or alcohol information, if drug or alcohol tests were ordered or treatment provided by my physician
- 2- Psychiatri or psychological information, if psychiatric or psychological treatment was given by my physician
- 3- HIV related information, if HIV related tests were ordered by my physician
- 4- This consent may be revoked by me at any time by submitting a written revocation notice, except to the extent that action has been taken in reliance thereon, and that this consent will remain in force in order to effectuate the purposes for which it was given

The information to be released is:

<input type="checkbox"/> History & Physical	<input type="checkbox"/> X-Ray/ Imaging Report	<input type="checkbox"/> Other Studies:
<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> Laboratory Results	<input type="checkbox"/> Entire Record
<input type="checkbox"/> Consultation Report	<input type="checkbox"/> EKG, Stress Tests, Echo	<input type="checkbox"/> Dates of Service:
<input type="checkbox"/> Operative/Procedure Report	<input type="checkbox"/> Allergy Test Results	From: _____
<input type="checkbox"/> Pathology Report		To: _____
<input type="checkbox"/> EXCEPTION: I do not give permission to release: _____		

FEES FOR COPYING RECORDS

Search & Retrieval -	\$16.94
Pages 1-20 -	\$1.13
Pages 21-60	.85¢
Pages 61- Onwards	.29¢

Records will be copied upon receipt of check or Money Order.
Made Payable To:
Dr. Deborah Ramanathan

Note:

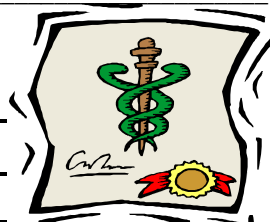
- *Allow 10 working days for processing and mailing
- *We will not be able to copy your records until payment is received.

Dated: Month: Day: Year:

Consent expires on: Month: Day: Year:

Patient Signature: _____

Signature of Authorized Representative: _____



Office use only	S&R Fee	\$16.94	Total	Pmnt Rcvd: _____
Total Pages	1-20	x 1.13 = _____	\$ _____	Date Rcvd: _____
#	21-60	x .85 = _____		Date Sent: _____
	61-xx	x .29 = _____		Released to: _____