REVOLUTIONARY HEALTH SERVICES

Authorization to Release Medical Records

Date (MM/DD/YY): _____ / _____ / _____

Please release my records to:

Revolutionary Health Services, LLC
1121 General Washington Memorial Blvd.
Washington Crossing, PA 18977
ATTN: Dr. Jennifer Kitchen

E-mail: office@RevolutionaryHealthServices.com
Phone: (215) 321-1371
Fax: (215) 321-1378

I am under the regular care of Dr. Jennifer Kitchen. The purpose of this Authorization is to transfer my medical records. Unless I direct otherwise, Dr. Jennifer Kitchen should receive my complete medical record, including HIV status, drug and alcohol treatment information, and mental health treatment information.

Signed: _____

Printed Name: _____

Phone: (_____) _____ - _____

Date of Birth (MM/DD/YY): _____ / _____ / _____