Pinnacle Physicians Group

Patient Name: _____DOB: _____

I hereby request my medical records to be:

TRANSFERRED FROM: _____

SEND RECORDS TO

__Frankford Avenue Family Practice
8846 Frankford Avenue
Philadelphia, PA. 19136

__Oxford Circle Family Medicine
5363 Oxford Avenue
Philadelphia, PA. 19124

__Stoltz&Hahn Medical Assoc.
339 East Street Road
Trevose, PA. 19053

__Woodhaven Family Medicine
1336 Bristol Pike
Bensalem, PA. 19020

__Dr. Brian K. Stein
3790 Morrell Avenue
Philadelphia, PA. 19114

__ Ashton Family Medicine
2981 Grant Avenue
Philadelphia, PA. 19114

__ Dr. Brad Millman
1336 Bristol Pike
Bensalem, PA. 19020

__ Parkwood Medical Practice
12401 Academy Road
Philadelphia, PA. 19154

__ Burstein Medical Assoc.
1718 Welsh Road Suite A
Philadelphia, PA. 19115

__ Murray Brand, DO and Assoc.
7524 Frankford Avenue
Philadelphia, PA. 19136

__ Street Road Medical Assoc.
2938 Knights Road
Bensalem, PA. 19020

The purpose of this release of information is to transfer my medical records to my new physician. Unless I direct otherwise, the party designated above will receive a copy of my complete medical records, including HIV status, drug or alcohol treatment, mental health information, and sexually transmitted disease treatment information.

Please list any exclusions: _____

My Name: _____
Address: _____
Phone: _____

Signature: _____ Date: _____