Medical Record Transfer Form

I hereby authorize : David N. Brotman, MD

Or his associates at:

Langhorne Surgical Group, P.C.
1205 Langhorne-Newtown Road
Suite 403
Langhorne, PA 19047

To release all of my medical records in his possession, including chart notes and correspondence, lab and x-ray results, vascular study reports, OR reports, discharge summaries and photographs, to:

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Patient Name: ________________________________

Date of Birth: ________________________________

Social Security No.: _____ - _____ - ________

Authorized Signature: ________________________
(Patient or Guardian)