NIM Longevity
A Functional and Holistic Approach

PATIENT RECORDS – RELEASE OF INFORMATION FORM

for Previous and/or Current Medical Providers

I, _____, _____/_____/_____,
(Print Patient's Name) Date of Birth (Patient)

Hereby authorize the previous and/or current doctor and medical provider listed below:

Name: _____

Address: _____

_____

Telephone: _____

To release to: **Val Koganski, MD, PC**
St. Mary's Medical Building
1205 Langhorne Newtown Road
Suite 202
Langhorne, PA 19047
Phone: 215-750-7000
Fax: 215-750-9572

Any and all medical information of examination(s) rendered by your department/office to the patient named above.

From: _____/_____/_____ To: _____/_____/_____ Except:_____

_____

_____
Signature of Patient / Patient Representative / Legal Guardian

_____ _____/_____/_____
Print name of person signing this Form Today's Date

One Summit Square
1717 Langhorne-Newtown Road
Suite 402
Langhorne, PA 19047

Phone #: 215-750-7000
Fax#: 215-750-9572
Email: info@NIM.health
URL: https://www.NIM.health