



AUTHORIZATION FOR RELEASE OF INFORMATION to HNA

\_\_\_\_\_(Physician/Office Name)

are hereby authorized to release any medical information and records to

Houser Newman Associates for:

PATIENT NAME: \_\_\_\_\_ DOB: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

You are hereby released from all legal liability that may arise from the release of the information requested.

DATE: \_\_\_\_\_ SIGNATURE: \_\_\_\_\_

RELATIONSHIP IF SIGNED BY OTHER THAN THE PATIENT: \_\_\_\_\_

Main Office  
37 Medical Crossing Road  
Tamaqua, PA 18252  
P: (570) 386-5926  
F: (570) 386-2959

Nesquehoning Office  
40 East Locust Street  
Nesquehoning, PA 18240  
P: (570) 386-5926  
F: (570) 386-2959

Palmerton Office  
217 Franklin Avenue, Suite 105  
Palmerton, PA 18071  
P: (570) 386-5926  
F: (570) 386-2959