REGIONAL GI

2112 Harrisburg Pike, Suite 202, Lancaster, PA 17604-3200
Phone (717) 869-4600 Fax (717) 544-3501

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize _____ to release information from the records of
(Health Care Provider/Facility)

_____ _____
(Patient's name – include # to contact if needed) (Date of Birth)

to _____
(Person, Organization, Agency – include address)

for the purpose of: _____

Specifically, the following reports will be included:

_____ Discharge Summary
_____ Operative Reports
_____ X-ray Reports
_____ Consultation Reports
_____ Entire Medical Record
_____ History and Physical Examination
_____ Laboratory Reports
_____ Physician Progress Notes
_____ Abstract of pertinent parts of records
_____ Other, please specify: _____

Dates: _____

Types of Records: _____

UNLESS YOU SIGN HERE, NO INFORMATION ABOUT ALCOHOL/SUBSTANCE ABUSE, HIV/AIDS, OR MENTAL HEALTH WILL BE DISCLOSED:
YES, DISCLOSE THIS INFORMATION * _____
NO, DO NOT DISCLOSE THIS INFORMATION * _____

This information is being disclosed to the above person, organization, or agency from records whose confidentiality may be protected by the Pennsylvania Law, Act 63, and/or Pennsylvania P.L. 817, and/or Federal Public Law 93-282 and/or Pennsylvania Law, Act 148. Information disclosed from this authorization might be re-disclosed by the recipient and might no longer be protected by the Health Insurance Portability and Accountability Act if the recipient is not a covered entity.

If the only reason you have asked us to provide a health care service is so that we can create information to be disclosed to a third party, such as for employee physicals, we may refuse to provide the service if you refuse to sign this form. Otherwise, your treatment will not be affected by your refusal to sign this form. I understand that I have no obligation whatsoever to disclose any information from my record and I understand that I may revoke this consent at any time by notifying Regional GI in writing; and specifying a date, time, event or condition upon which my consent will expire. This will not prohibit Regional GI from completing any actions it initiated prior to my revocation and which rely on my records for completion. I have had this form read and explained to me and I understand its contents.

_____ _____
(Date of authorization) (Print patient's name)

_____ _____
(Signature of patient/authorized person) (Relationship to patient)

_____ _____ _____
(Witness) (Date of birth) (Social security #)

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THIS PORTION TO BE COMPLETED WHEN A PATIENT IS UNABLE TO GIVE WRITTEN CONSENT:
We, the undersigned, do verify that the above authorization has been read to the patient and that he/she understands the nature of the release and freely gives his/her verbal consent for release of the information.

_____ _____ _____
(Date) (Signature of responsible witness) (Signature of responsible witness)

** This authorization expires 90 days from the date executed per state and federal law.