mlga Main Line Gastroenterology Associates

Authorization to Release Medical Information

Patient's Name: _____DOB:_____

Address: _____Phone Number: _____

I authorize the following individual(s) or organization to make the disclosure of health information described below:

Main Line Gastroenterology Associates, P.C.

325 Central Ave
Suite 200
Malvern, PA.
19355 (fax)
610-647-2063

252 Lankenau Medical Bldg. East
100 Lancaster Avenue
Wynnewood, PA 19096
(fax) 610-896-5207

2050 West Chester Pike
3rd Floor
Havertown, PA 19083
(fax) 610-853-3687

Riddle Memorial Hospital
1088 W. Baltimore Pike HCC II
Suite 2407 - Media, PA 19063
(fax) 610-892-9535

The information may be disclosed to, and used by, the following individual(s) or organization(s):

Name(s): _____

Address: _____

for the following purpose(s): _____

_____

This authorization is limited to the following information:_____

_____ (include specific dates of treatment)

The information to be disclosed may include the following items (unless crossed out by me):

Drug and Alcohol abuse and treatment information
Information regarding Human Immunodeficiency Virus (HIV), including laboratory test results
Genetic testing and counseling, if applicable
Diagnosis of AIDS or ARC, if applicable
Psychosocial history
History and Physical examination
Physician Notes
Rehabilitation Notes
Consultations
Progress Notes
Labs, X-rays and Tests
Nurses' Notes
Billing Information
Discharge Summary
Other (specify):_____

This authorization may be revoked by me at any time except to the extent that _____ [name of organization authorized to make the disclosure] has already acted in reliance on this authorization. If I revoke this authorization, I need to do so in writing and mail or hand deliver it to _____[name and address of person or department authorized to make the disclosure]. If not revoked by me, this consent will terminate one year from the date of my signature.

I understand that I have a right to inspect the information to be disclosed. I understand that I need not sign this authorization in order to ensure health care treatment, payment, enrollment in my health plan, or eligibility for benefits. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected.

Signature of Patient or Legal Representative:_____ Date:_____

If signed by a Legal Representative, relationship to patient:_____