Gastrointestinal Specialists
University Level Care in Your Neighborhood

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AUTHORIZATION TO RELEASE MEDICAL RECORDS

TO:_____ FAX #:_____

PLEASE FAX RECORDS TO: 215-632-6533

I _____ **(Please Print)** DATE OF BIRTH:_____
Authorize you and any physicians, nurse, or other healthcare professional who has attended me, or any hospital at which I have been confined to furnish medical records to Gastrointestinal Specialist, Inc, or an authorized representative.

Any and all information that may be requested regarding my physical or mental treatment rendered to allow them to examine any X-ray films, labs, and cardiac records (EKG, stress test, echo…etc) taken of me or records regarding my physical or mental treatment. I also authorize the release of mental health, drug, and alcohol use information or treatment records under the same terms and conditions. A photocopy/fax can be used instead of original.

I have read and understand the terms of this authorization. By my signature below, I hereby knowingly and voluntarily authorize the practice to use or disclose to the recipient my health information.

_____	_____	_____
Signature of Patient	Date	Witness

If patient is a minor or otherwise unable to sign this authorization obtain the following signatures:

_____	_____	_____
Signature of Guardian	Date	Description of Authority

Locations:

[ ] Aria Torresdale Hospital
10800 Knights Rd Ste 240
Philadelphia, Pa 19114
215-632-3500 (Phone)
215-632-6533 (Fax)

[ ]Bala Cynwyd Office
10 Presidential Blvd Ste 124
Bala Cynwyd, Pa 19004
610-664-9700 (Phone)
610-664-6391 (Fax)

[ ] Bucks County Office
825 Towne Center Drive Ste 148
Langhorne, Pa 19047
215-702-7090 (Phone)
215-702-7130 (Fax)