Blair Gastro
Gastroenterology
Associates

810 Valley View Boulevard, Altoona, PA 16602 Phone: 814-946-5469 Fax: 814-946-4970

Request For Release of Medical Reports

1. Patient's Full Name: _____ DOB:_____

2. Patient's Address:_____

3. Describe in detail the health information to be released to/from Dr. _____
   at Blair Gastroenterology Associates:
   _____
   _____
   This release is valid only for the information detailed above and is not to be used to release any outside/additional information. Subsequent requests for copies of the same records for personal use will be assessed a fee.

4. To/From whom does the patient want the medical information released:

   Name: _____

   Address:_____

   Phone: _____Fax:_____

5. Purpose of this request for release of medical records:
   _____

I have read and understand this authorization, and I authorize that the above-referenced medical information be released to Blair Gastroenterology Associates as per the above guidelines. I understand that my medical records may include psychiatric information, drug and alcohol information, and/or HIV information.

I understand that this consent is voluntary and that I may revoke this authorization at any time (except to the extent that action based on this consent has already been taken) by written, dated, and signed communication to Blair Gastroenterology Associates.

Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer will be protected by the Health Insurance Portability and Accountability Act ("HIPAA"). I understand that I may refuse to sign this authorization. If I refuse, the identified records will not be disclosed and my treatment will not be affected. I understand that I am entitled to receive a copy of this completed authorization.

_____ _____
Signature of Patient Date

_____ _____
Signature of Personal Representative of Patient Relationship to Patient

_____ _____
Witness Date