



**U.S. Digestive Health and Affiliates
Authorization for Release of Medical Record Information**

Practice Location Name/Address: _____

Fax number: _____

Patient's Name: _____

Social Security Number: _____ Date of Birth: _____

Address: _____

I hereby authorize the release of my health information as listed below:

Person or entity authorized to receive information: _____

Address for Release: _____

Purpose of Release: _____

Dates of Service: All Dates of Services: _____

Description of Information: Medical Record Billing Record Complete Record

Specific Information: _____

Special Records: Include the following medical records if such information is included in your records. Checking the boxes is not a representation that such information exists. See waiver below.

- Include Drug and Alcohol Treatment Records (protected by the Pennsylvania Drug & Alcohol Abuse Control Act, 71 P.S. 1690.108)
- Include Mental Health Records (protected by the Mental Health Procedures Act, 50 P.S. 7111)
- Include AIDS/HIV related records (protected by Confidentiality of HIV-Related Information Act, 35 P.S. 7607)
- Include limited AIDS/HIV-Related records as follows: _____
- Include Sexual Abuse/Assault and Domestic Violence Counseling Records (protected by 42 PA C.S. A 5945.1 and 23 PA C.S.A 6116, respectively)

Please provide the records in the following format if possible:

- Electronic Mobile device/disk Secure Email: _____
- Paper

1. This authorization will expire: Date: _____ Event: _____ 1 year
2. Unless otherwise specified, this authorization will expire one year after the date of the request
3. I understand that I may revoke this authorization at any time by notifying my provider or by notifying the provider or the entity that is authorized to receive these records. I understand that



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revocation will not have any effect on actions taken prior to my revocation and will not apply to information that has already been released in response to this authorization.

4. This authorization is voluntary. I can refuse to sign this authorization.
5. I understand that if the organization authorized to receive the information is not a health plan or a health care provider, the information may no longer be protected by federal privacy regulations
6. I understand that this information may be re-released by the recipient and no longer protected
7. By signing below, I certify that I understand the nature of this Release
8. I understand that the provider named above may not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization
9. If mental health records are being released as permitted by the Mental Health Procedures Act, I understand that I have a right, subject to 55 PA Code 5100.33 to inspect the material to be released
10. If AIDS or HIV-related information is being released, this information has been disclosed to you from records protected by Pennsylvania law. Pennsylvania law prohibits you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or is authorized by the Confidentiality of HIV-Related Information Act. A general authorization for the release of medical or other information is not sufficient for this purpose.
11. By signing below, I authorize the release of the medical information requested and specifically waive the confidentiality protection afforded by Pennsylvania statutory law for the Special Records indicated above

This waiver is applicable only to this request and is not meant to be a general waiver.

Signature of patient or Patient’s Representative/Guardian

Date

Relationship to Patient

Contact info: Please provide contact information in the event there is a question related to the request.

Phone: _____

Email: _____

**US Digestive Health at Blair - Fax Number: 814-946-1314
Phone Number: 814-946-5469**

Employee Requesting: _____