Harford Gastroenterology Associates

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Pathologist

HIPAA-Compliant Authorization to Release Medical Records

Patient's Full Name _____ **Patients Date of Birth** _____

Address _____ **City, State, Zip Code** _____

Patient's Telephone _____

I hereby authorize you to release to HARFORD GASTROENTEROLOGY ASSOCIATES a copy of my medical records. These records will be used for continuing medical care. I reserve the right to revoke this authorization in writing at any time. Furthermore, I understand that this Protected Health Information may be re-disclosed by the recipient and thus, is no longer protected under privacy rules.

By signing this authorization, I understand that medical records released may contain information related to HIV status, AIDS, sexually transmitted diseases, mental health, drug and alcohol abuse, etc. I understand that release of psychotherapy notes requires an additional authorization.

INFORMATION TO BE RELEASED FROM:

Organization/Contact Name _____

Street Address _____

City, State, Zip Code _____

Telephone Number _____

INFORMATION TO BE RELEASED TO:

Harford Gastroenterology Associates
100 Walter Ward Boulevard
Suite 100
Abingdon, MD 21009
Phone: 443-347-4700
Fax: 443-643-4707

TYPES OF RECORDS REQUESTED

- □ Date of Service: From_____ to _____
- □ Health care information related to the following treatment or condition _____
  _____
- □ Laboratory/diagnostic tests_____
  _____
- □ Other _____
  _____

Purpose or need for this information: □ Continuing Care □ Copies for Own Use □ Other

Date _____ Signature of Patient or Legally Responsible Party _____ Description of Authority to Act for the Individual _____