Harford Gastroenterology Associates

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HIPAA-Compliant Authorization to Release Harford Gastroenterology Associates 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:	**INFORMATION TO BE RELEASED TO:**
Harford Gastroenterology Associates	____________________ Organization/Contact Name
100 Walter Ward Boulevard	
Suite 100	____________________ Street Address
Abingdon, MD 21009	
Phone: 443-347-4700	____________________ City, State, Zip Code
Fax: 443-643-4707	
	____________________ Telephone Number & Fax Number

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