REGIONAL GASTROENTEROLOGY
Associates of Lancaster, LTD.

AUTHORIZATION FOR RELEASE OF RECORDS

(The records may include confidential HIV-related information, drug and alcohol information, and psychiatric information.)

If you sign this form, your records from Regional Gastroenterology Associates of Lancaster, Ltd. will be released to the individual or agency specified below. Your records may include documents generated in our office, correspondence between other treating physicians, and records generated during past hospitalizations. Those records may also contain HIV-related information, drug and alcohol information, and psychiatric information. HIV-related information includes any information relating to the testing for Human Immunodeficiency Virus, which is the cause of AIDS, or any information indicating potential exposure to HIV.

Please complete Part A or Part B:

A. To obtain information for RGAL	B. For RGAL to release information
I hereby authorize ______________________________ to release the medical records (including confidential information of: ______________________________ (name of person whose confidential information will be released) to the following person or organization: Regional Gastroenterology Associates of Lancaster, Ltd. 2104 Harrisburg Pike, Suite 300 P.O. Box 3200 Lancaster, PA 17604-3200	I hereby authorize Regional Gastroenterology Associates of Lancaster, Ltd. to release the medical records (including confidential information) of ____ (name of person whose confidential information will be released) to the following person or organization: ____ (Person to Whom Information is Being Released) ____ (Address) ____ (Address) ____ (Telephone number, if known)

1. This authorization is for the use and/or disclosure of the following protected health information:

   _______ All medical records (including confidential HIV-related information, drug and alcohol information, and/or psychiatric information).

   _______ Records restricted to only

   ____

2. The purpose of the use or disclosure is as follows:

______ At the request of the patient or patient's personal representative.

______ As follows: ____

____

Expiration date or expiration event: ______________________________

3. This authorization will expire 90 days from signature date or on ________________, unless sooner revoked by me. I understand that I may revoke this authorization at any time, except to the extent that previously authorized disclosure has been acted upon, by notifying our privacy officer, Regional Gastroenterology Associates of Lancaster, Ltd., at the above address in writing. A revocation will not impact any action taken prior to our receipt of the revocation in reliance of this authorization.
4. We may not condition treatment on your agreement to sign this authorization.
5. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the persons listed in Part B and may no longer be protected.
6. I understand that if the use/disclosure is for myself, that I will receive five copied pages from my medical record free of charge. If my request exceeds five pages, I may be charged in accordance with the above per page fee structure.

I understand the nature of this Authorization.

____

(Signature of Patient/Patient's Date of Birth/Patient's Social Security Number)

____

(Other Person Authorized to Sign/Relationship of Authorized Person to Patient)

______________________________ ______________________________

(Witness Signature) (Date Release Form Signed)

If this authorization is for the release of Mental Health Records or HIV-related information, the following statement must be included in the Authorization:

This information has been disclosed to you from records whose confidentiality is 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 authorization of the person to whom it pertains or is otherwise permitted by law. A general authorization for the release of medical or other information is not sufficient for this purpose.