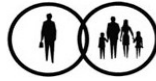


GETTYSBURG FAMILY PRACTICE, INC.

ADAM I. WASSERMAN, M.D.
DOUGLAS E. EYER, M.D.
WILLIAM J. ADAIR, M.D.



KRISTI L. ALLEN, CRNP
MELISSA C. KAMINSKI, PA-C

AUTHORIZATION TO RELEASE OR OBTAIN INFORMATION

I, _____, do hereby authorize
Gettysburg Family Practice, Inc.:

To Release My Medical Records To:

Patient's Responsibility To Forward Request to
Previous Provider to Obtain Prior Medical
Records:

Three horizontal lines for patient information.

Three horizontal lines for provider information.

Information from the record of: _____, D.O.B: _____

To release all of my medical records and office notes, including records from previous
physicians, institutions, organizations and professionals and including, confidential HIV related
information, drug and alcohol related records, all psychiatric/psychotherapy and mental health record, and
sexual abuse related records. All of these records will be released unless requested otherwise.

The purpose for obtaining these records is: _____ Continuing care (effective date of change of providers if
applicable - _____) _____ Insurance _____ Legal _____ Other

I understand there may be charges for the copies of my health record in accordance with Pennsylvania
Department of Health regulations and/or the Health Insurance Portability and Accountability Act. I also
understand that Gettysburg Family Practice uses a HIPAA compliant copying service for their medical records.

I understand that I may revoke this authorization in writing at any time and present my written revocation to
Gettysburg Family Practice. I understand that the revocation will not apply to information that has already been
released in response to this authorization. This authorization expires in 180 days, unless otherwise specified
as follows: _____.

I hereby authorize the use or disclosure of my individually identifiable health information as described above. I
understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to
obtain treatment or payment or my eligibility for benefits. I understand that if the organization authorized to
receive the information is not a health plan or health care provider, the released information may no longer be
protected by federal privacy regulations, and that it may be re-disclosed by the recipient.

Signature of Patient or Representative

Relationship to Patient

Date