GETTYSBURG FAMILY PRACTICE, INC.

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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:**
_____	_____
_____	_____
_____	_____

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

REV 6/11/19