SARATOGA SCHENECTADY GASTROENTEROLOGY ASSOCIATES, P.C.
848 ROUTE 50
BURNT HILLS, NEW YORK 12027-9511
Phone: (518) 831-1500 Fax: (518) 377-1677

FOR RELEASE OF MEDICAL RECORDS:

Patient Name: _____ DOB: _____

I, _____, authorize Saratoga Schenectady Gastroenterology to release my Protected Health Information, as described below, to:

Recipient(s) Information:

Name: _____

Mailing Address: _____

Phone #: _____ Fax #: _____

I request that the information to be released consist of the following (CHECK ALL THAT APPLY):

___ Complete Medical Record ___ Medical History, Evaluation Record ___ Immunizations

___ Treatment or Tests ___ Hospital Records Including Reports ___ X-Ray Reports

___ Allergy Records ___ Laboratory Reports ___ Prescription Data

___ Consultation Documentation ___ Surgical Reports

___ Other (Specify): _____

I also specifically authorize that any sensitive information regarding (CHECK ALL THAT APPLY):
___ HIV/AIDS ____ Substance Abuse (alcoholism or drug abuse) or ___ Mental Health Records

I understand that if the authorized recipient is not a provider, health plan, clearinghouse required to comply with federal privacy standards, the information disclosed pursuant to this authorization may no longer be protected by the federal privacy standards and my health information may be redisclosed by the recipient without obtaining any further authorization.

I have had an opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that it accurately reflects my wishes.

PLEASE NOTE: There is a $0.75 per page fee that will need to be paid prior to records being sent out. If you are requesting them to be sent directly to another physician we will waive that fee.

INDIVIDUAL'S SIGNATURE: _____

DATE: _____