CENTRAL BUCKS SPECIALISTS, LTD

599 W. State Street, Suite 200
Doylestown, PA 18901
Phone: 215-345-6050
Fax: 215-345-6568

Robert H. Hale, MD
Joseph Minissale, DO
Louis Morsbach, Jr., MD
Alan Chang, MD
Sandhya Salguti, MD
Victor Araya, MD
Kiley Walp, DO

AUTHORIZATION TO USE/DISCLOSE HEALTH INFORMATION

Patient Name_____ Date of Birth_____

I hereby authorize that the protected health information regarding the above-named person be forwarded:

FROM: Physician/Facility: _____
Address: _____
City _____ State: _____ Zip Code _____

TO: Person/Facility_____
Address: _____
City _____ State: _____ Zip Code _____

Information to be Released: (check all that apply)

□ Entire Record
□ Recent Office Notes
□ OR Reports
□ Pathology Reports
□ Recent Labs
□ Procedure Reports (EGD, Colonoscopy, ERCP, EUS)
□ Radiology Reports (CT, MRI, U/S, HIDA)
□ H & P, Consults, D/C summaries (from _____ to present)
□ Other _____
_____

Information disclosed under this authorization might be re-disclosed by the recipient and this re-disclosure may no longer be protected by federal or state law.

Specially Protected Information: The following information is specially protected by state and/or federal law. Please indicate below whether you would like the following information to be released.

Substance abuse records (drug or alcohol)	Yes □	No □	Initials_____
Mental Health records protected by Mental Health Procedures Act	Yes □	No □	Initials_____
HIV/AIDS related information	Yes □	No □	Initials_____

Purpose for the Disclosure: (Please check one)

□ Personal Use □ Continued Medical Care □ Insurance □ School □ Legal □ Other (please specify)_____

Psychotherapy notes will not be covered unless specifically covered in a separate authorization. Please note that other mental health and behavioral information included in any checked category will be covered by this authorization unless excluded below.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Privacy Officer. I understand that the revocation will not apply to information that has already been released in response top this authorization. Unless otherwise revoked, this authorization will expire on the following date, event or condition:

Expiration: This authorization expires as of the following date_____

_____ _____
Signature of Patient (or authorized representative) Date

Personal Representative Information (as applicable):

_____ _____
Name of Personal Representative Date