

**GATEWAY MEDICAL ASSOCIATES
AUTHORIZATION TO RELEASE RECORDS**

PATIENT NAME _____ BIRTHDATE _____

PATIENT'S SIGNATURE (REQUIRED) _____
(OR PARENT / GUARDIAN'S SIGNATURE FOR MINOR CHILDREN)

ADDRESS _____

I AUTHORIZE GATEWAY MEDICAL ASSOCIATES

_____ TO RELEASE MY MEDICAL RECORDS TO:

_____ TO OBTAIN MEDICAL RECORDS FROM:

DOCTOR / HOSPITAL, ETC. _____

STREET / CITY / STATE / ZIP _____

_____ ENTIRE MEDICAL RECORDS _____ LAST FIVE (5) YEARS _____ SPECIFY _____

The following consent may be revoked at any time upon written notification, except to the extent that the person making the disclosure has already acted in reliance on it.

I GIVE SPECIAL PERMISSION TO RELEASE ANY INFORMATION REGARDING:

_____ Information relating to drug or alcohol abuse, dependence or treatment

Patient Signature Date

_____ Psychiatric / Mental Health / Psychotherapy records

Patient Signature Date

_____ HIV- Purpose of Disclosure _____

Patient Signature Date

Date of Expiration _____

This information has been disclosed to you from records 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 consent of the person to whom it pertains or is authorized by the Confidentiality of HIV-related Information Act. A general authorization for the release of medical or other information is not sufficient for this purpose.