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AUTHORIZATION TO RELEASE MEDICAL RECORDS

I, ______________________________________, authorize any physician, nurse, or other healthcare professional who has attended to me, or any hospital at which I have been confined to furnish to ***Bucks County Gastroenterology***, or an authorized representative, any and all information that may be requested regarding my physical or mental condition and treatment rendered therefore and, if necessary, to allow them to examine any x-ray films taken of me or records regarding my physical or mental condition or treatment. In addition, I also authorize the release of psychiatric/psychotherapy records, mental health records and drug/alcohol use information or treatment records under the same terms and conditions. A photocopy/fax copy of this instrument may be used instead of the original.

Witness: ______________________________

**Please note a witness may any BCGI staff, representative, or my designee*

Patient Signature: ____________________________ Date: ______________________