Harrisburg Gastroenterology, Ltd.

DISCLOSURE OF CONFIDENTIAL INFORMATION

This Is to Certify That: _____

(Patient Name)

Gives permission for Harrisburg Gastroenterology to provide information regarding my medical care (EXCLUDING DOCTORS) to:

NAME	PHONE NUMBER	RELATIONSHIP
_____	_____	_____
_____	_____	_____
_____	_____	_____

Patient's Email Address: _____

Patient's Signature: _____

Parent or Guardian Signature: (if applicable) _____

Patient's Date of Birth: _____

_____ I (INITIALS) grant permission to Harrisburg Gastroenterology to view my external health history (including prescription history) faxed or electronically received from other healthcare providers through the HIE (Health information exchange).

FOR OFFICE USE BELOW THIS LINE

Witnessed By _____ Date _____

Form – 60 rev 02/2022