Center for Digestive Health

Medical Records Fax: 586-726-8527

Patient Authorization for Disclosure of Health Information

Patient Name: _____Date of Birth _____/_____/_____

Address: _____ City: _____ State: _____ Zip: _____

Email address: _____ Phone: _____ Social Security xxx-xx-_____

I request that my protected health information from The Center for Digestive Health be disclosed to:

Recipient Name: _____

Address: _____ City: _____State:_____ Zip: _____

Phone: _____ Fax # (healthcare provider only):_____

Records needed by (for healthcare providers appointments)_____

I authorize the following protected health information to be released: Date(s) of Service_____

_____ Consultation	_____ History and Physical	_____ Procedure Reports
_____ Test Results	_____ Pathology/Laboratory Report	_____ Operative Report

Other: _____

☐ Consent to release **Entire Medical Record**, for date(s) of service_____, including all information noted above.

I understand that the information in my health record may include information relation to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment of alcohol or drug abuse.

☐ By checking this box, I attest that I do not want records of substance abuse, mental health or HIV/AIDS released under this authorization.

Purpose for requesting information: ____ Legal ___ Insurance _____Personal ____Transfer/Continuity of Care

By signing this authorization form, I understand that:

- Request or copies of medical records are subject to reproduction fees in accordance with federal/state regulations.
- I have the right to revoke this authorization at any time. Revocation must be made in writing and presented or mailed to the HIPAA Officer at Center for Digestive Health.
- Unless otherwise revoked, this authorization will expire six months from the date of signature.
- Any disclosure information carries with it the potential for unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

I certify that I have read the provisions set forth in this authorization. I understand and agree to its terms.

_____

Patient Name (please print)

_____ _____/_____/_____

Signature of Patient Date