Troy Gastroenterology, P.C.

And its Affiliated Covered Entities: Center for Digestive Health, Macomb Endoscopy Center, and Surgical Centers of Michigan

Medical Records Fax: 586-726-8527

Medical Records Release Form - 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

_____ Entire Medical Record, for date(s) of service _____, including all information noted above.

Other:_____

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:

- Requests 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, 1701 E. South Blvd, Rochester, Michigan 48307. Unless otherwise revoked, this authorization will expire six months from the date of signature.
- Treatment, payment, enrollment or eligibility for benefits may not be conditioned on obtaining this authorization if such conditioning is provided by the Privacy Rule.
- 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.

☐ I agree for records to be sent via unsecure email at **No Charge**. Records will be sent to email on file, unless a different email address is provided. *Once the records leave our network, the Patient (or their representative) assumes responsibility for the records.*

_____ _____

Patient Name (please print) Email Address

_____ _____/_____/_____

Signature of Patient Date