FLINT GASTROENTEROLOGY ASSOCIATES, PC

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient: _____ **Birthdate:**_____
Address: _____ **SSN#:** last four: _____
_____ **Telephone:**_____

I, _____hereby authorize,

The following physician and/or entity: _____
_____

To disclose the following protected health information. I agree to disclosure of information contained in my patient records, including alcohol and drug abuse records protected under the regulations in 42 Code of Federal regulation, Part 2 , if any: social services records , in any; and psychological services records, if any; including communications made by me to any employee of this office; or any records pertaining to HIV infection, acquired immunodeficiency syndrome or acquired immunodeficiency syndrome related complex or a test for any such disease, including records protected under ACT 488, Public Acts of Michigan, 1988, if any; or any other records or test related to any other sexually transmitted disease, if any; which may be contained within the records specified below.

Specific *type* of information to be disclosed, (including from and to dates)

___Any and All Records ___Diagnostic Reports Only ___ Laboratory Results Only
___Chart Notes Only ___Consultations Only from date ____/___/___ to date ___/___/___

Other_____ from date ____/___/___ to date ___/___/___

The above protected health information may be disclosed to and used by the following individual or entity:
Name: **FLINT GASTROENTEROLOGY ASSOCIATES Dr.** _____
600 Health Park Blvd, Suite C, Grand Blanc MI 48433
Phone: _____ Fax: _____ ATTN:_____

The purpose and need for disclosure: ___Transfer of Care ___Attorney Request ___Disability ___Workers' Comp
___Social Security ___Insurance ___Other_____

This authorization shall be in force and effect until (Date) _____/____/____ or upon the following expiration event _____. If I fail to specify an expiration date, event or condition, this authorization will expire in six months.

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing, by presenting my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal and state law. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, they may be directed to the privacy office or contact.

_____
Signature of Patient or Legal Representative

_____ _____
If Signed by Representative, Give Relation to Patient Witness