Flint Gastroenterology Associates, PC
600 Health Park Blvd. ● Suite D Grand Blanc, MI 48439
PHONE 810-603-8400 FAX 810-603-8410

AUTHORIZATION TO RELEASE OF HEALTH CARE INFORMATION

Patient_____ **Birthdate**_____

Address_____ **SSN#(last 4)**_____

_____ **Phone**_____

I, _____**,** hereby authorized 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.

Released FROM: _____

Released TO: **FLINT GASTROENTEROLOGY ASSOCIATES, PC**

Specific type of information to be disclosed:___Any and All Records ___Diagnostic Reports Only ___ Laboratory Results Only ___Chart Notes Only ___Consultations Only ___ Immunizations ___ Other_____ from date ____/___/___ to date ___/___/___

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

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.

_____ _____ _____

Patient / Personal Representative **Printed Name** **Date**

If personal Representative –Relationship to pt _____

(RETURN THIS FORM WITH YOUR PATIENT PAPERWORK)

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