G.I. MEDICINE ASSOCIATES, P.C.
Authorization For Use or Disclosure of Medical Record Information

Patient Information

Patient Name: ____ Date of Birth: __________________

Address: ____

Phone Number: _______________________ Social Security Number: ________________________

Release Information From

I authorize the use or disclosure of the above named patient's information as described below:

The following individual or organization is authorized to make the disclosure (Please print):

□ G.I. Medicine Associates P.C.
28963 Little Mack, Suite 101
St. Clair Shores, MI 48081
586-447-0700
586-447-0795 fax

□ Name: ___________________________________
Address: _________________________________
____
Phone: ___________________________________
Fax: _____________________________________

Release Information To

The information may be used by or disclosed to the following individual or organization:

□ Name: _______________________________
Address: _____________________________
____
Phone: _______________________________
Fax: _________________________________

□ G.I. Medicine Associates P.C.
28963 Little Mack, Suite 101
St. Clair Shores, MI 48081
586-447-0700
586-447-0795 fax

Specific Information to be Disclosed:

_________ Laboratory Reports ___________ Procedure Reports __________ Radiology Reports

_________ Other ____

I understand that the information contained in my patient record may include information about alcohol and drug abuse, behavioral or mental health and infections.

The purpose and need for this disclosure is:

_____ Personal Records _____ Continuation of Healthcare _____ Other (please specify) ______________

Unless I specify differently, this authorization will **expire in ninety (90) days**. 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 or state law. I understand that the practice will not condition my treatment on whether I provide authorization for the requested use or disclosure. I understand that I have a right to:

- Inspect or copy my protected health information to be used or disclosed as permitted under federal law (or state law to the extent the state law provides greater access rights).
- Refuse to sign this authorization.

Date: ________________________________

____
Signature of Patient or Personal Representative

____
Print Name of Patient or Personal Representative

____
Signature of Witness

____
Print Name of Witness

12/10/14