DHI Digestive Health Institute
A Pinnacle GI Partner

Michigan Gastroenterology Institute & Capitol Colorectal Surgery

Release of Information

(517) 332-1200 option 7

Patient Name _____ **Date of Birth** _____

Address _____
(Street) (City) (State) (Zip)

Email _____ **Phone** _____ **SSN:** XXX-XX- _____

I request that my protected health information from Digestive Health Institute to be disclosed to:

Recipient Name _____

Address _____
(Street) (City) (State) (Zip)

Phone _____ Fax (healthcare providers only) _____

Records needed by (for healthcare providers appointments) _____

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

☐ Consultation ☐ History & Physical ☐ Procedure Reports

☐ Test Results ☐ Pathology/Laboratory ☐ Operative Report

☐ Entire Medical Record for date(s) of service including _____, 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 Digestive Health Institute, 1650 Ramblewood Dr, East Lansing, MI 48823. 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 (print please) _____ **Email Address:** _____

Signature _____ **Date:** _____