PINNACLE
GI PARTNERS

517-332-1200 option 7

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 Digestive Health Institute to 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 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 (please print) Email Address

_____ _____/_____/_____
Signature of Patient Date