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Board Certified in Gastroenterology

www.digesthealth.com

DHA Digestive Health Associates PLC

Authorization to Request/Release Medical Records Information

☐ **I would like my records to be released/sent to:** _____

☐ **I would like Digestive Heatlh Associates to obtain records from:** _____

Patient's Name _____ Date of Birth _____

Patient's Address _____

City _____ State _____ Zip _____

Telephone (_____) _____ Fax (_____) _____

Patient's Social Security Number: _____ Sex: ☐ M ☐ F

Reason for disclosure/release of information: _____

Address to send Information/Fax (write fax #) (if address/fax is not enclosed, documents will be mailed to the requestor's address): _____

Information to be released: Please Check All Applicable Records to Release

☐ All Medical Records — Dates of Service: From _____ to _____

☐ Diagnostic Records (labs, CT scans, ultrasounds) — Dates of Service: From _____ to _____

☐ Surgical Records — Dates of Service: From _____ to _____

☐ Other: _____ — Dates of Service: From _____ to _____

I understand and agree that the patient records released may include: (a) alcohol and drug abuse information protected under the regulation in 42 code of federal regulations, Part 2, if any, (b) psychological and/or social service information, if any, and (c) information about HIV, AIDS, or ARC protected under MCL 333.5131, or any communicable disease.

This authorization is valid for a maximum of 90 days from the date of signature below or until expressly revoked by the undersigned.

The Physician/s, Facility, and their employees are released from legal responsibility or liability for the release of the above information to the extent indicated and authorized here. The recipient of the enclosed information is not authorized to use this patient's medical records for any other purpose than for that stated above or to disclose any information from the record to any other person or facility without specific written authorization from the patient or the patient's legal guardian to do so. This authorization is only valid within 90 days of the patient's date of signature on this form. The patient may revoke this authorization at any time except to the extent that records have already been released pursuant to this release.

_____ _____

Signature of Patient — Date

_____ _____

Signature of Parent of a Minor Patient or Legal Guardian* — Relationship

*If legal guardian, a copy of current order appointing the guardian must be attached. Please send records to the attention of the physician at the address listed.