Kalamazoo Gastroenterology Hepatology | Digestive Health Center

I hereby authorize the use or disclosure of my Medical Information(PHI), as described below:

Patient Name ____________________ Date of Birth ____________________

Medical Information (PHI) to be used or disclosed:

Entire Record

Operative Note Pathology Results Pictures

Radiology Reports Office Visits Lab Results

Other: ____________________

Purpose for Release/Disclosure of Information: Continuing Care Personal Use

Attorney/Legal Insurance Disability Other ____________________

I authorize for my Medical Information to be Released From:

Doctor ____________________ Phone ____________________

Address ____________________ Fax ____________________

City State Zip

Medical Information is to be Disclosed To:

Doctor ____________________ Phone ____________________

Address ____________________ Fax ____________________

City State Zip

Authorization expires 1 year from date of signature unless otherwise specified: Other ____________________

I further authorize that a photocopy of this release may be used in place of the original.

I understand that there may be a charge that I am responsible for prior to the completion of the request.

Signature ____________________ **Date** ____________________

Relationship of consenting party to patient ____________________ **Signature of Witness** ____________________

Kalamazoo Gastroenterology Hepatology Digestive Health Center

AUTHORIZATION FOR THE USE OR DISCLOSURE OF MEDICAL RECORDS

(PROTECTED HEALTH INFORMATION)

Upon request, our practice will provide a Revocation of Authorization Form to any individual seeking to revoke a previously signed Authorization Form. Upon receipt of a signed and dated Revocation of Authorization Form, we will terminate all uses and disclosure of the individual's Protected Health Information covered by the specific Authorization that is revoked. The revocation will be effective on the date that the signed form is received or the date specified on the form, whichever is later and shall not apply to information used or disclosed prior to the individual's revocation.

This revocation must be signed and dated by the patient or the patient's authorized Personal Representative.

The signature must be identified as that of the Patient or the Patient's authorized Personal Representative. If the person signing the Authorization is the Patient's authorized Personal Representative, then the appropriate authorizing law or reason must be noted on the form

An individual may revoke at anytime a signed authorization but only as to future uses and disclosure of Protected Health Information. An individual may not revoke his or her authorization to the extent of previously authorized uses or disclosures of the individual's Protected Health Information that relied on the Authorization, or if the Authorization was obtained as a condition of obtaining insurance coverage and other law provides the owner with the right to contest a claim under the policy, or the policy itself.

Protected Health Information that is used or disclosed under this Authorization may be subject to re-disclosure by the recipient, and the law will no longer protect the privacy of my Protected Health Information.
Our practice may not condition the provision to an individual of treatment, payment, enrollment in the health plan, or eligibility for benefits on the provision of a signed authorization from an individual except for the following:

1. Our practice may condition the provision of research-related treatment on provision of a signed authorization from an individual for the use r disclosure of Protected Health Information for research.

2. A health plan may condition, and deny enrollment in the health plan of eligibility for benefits on provision of an authorization requested by the health plan prior to an individual's enrollment in the health plan, if 1) the authorization sought is for the health plan's eligibility of enrollment determinations relating to the individual or for its underwriting or risk rating determinations and 2) the authorization is not for a use r disclosure of psychotherapy notes.

3. Our practice may condition the provision of health care that is solely for the purpose of creating protected health information for disclosure to a third party on provision of an authorization for the disclosure of the protected health information to such third party.