GASTROENTEROLOGY CONSULTANTS PLC

John D.Serini DO
Jeannie S. Wilcox PA-C

2093 Health Drive, Suite 101 • Wyoming • Michigan 49519 • Phone (616) 828-5727 • Fax (616) 828-5726 • Website: www.giconsultgr.com

AUTHORIZATION FOR RELEASE-PROTECTED HEALTH INFORMATION

Patient Name _____ Date of Birth _____

Address _____ Telephone _____

_____ Dates of Service _____

INFORMATION REQUESTED

History & Physical Discharge Summary Operative Reports ER Visits
Lab/Pathology Reports Office Notes/ Consult Reports Radiology Reports
Billing Invoices
Other _____

I would like copies of my health information indicated in the section above sent to:

TO: _____ From: _____

_____ _____

_____ _____

I authorize the release of health information contained in my medical records including:

- Information regarding communicable diseases and infections, such as defined by statue and Michigan Department of Public Health rules, which include venereal disease, Tuberculosis, Hepatitis A, B, C, Human Immunodeficiency (HIV), HIV testing.
- Alcohol and drug abuse treatment information protected unter the regulation in CFR 42, Part 2.
- Mental health treatment records, psychological services and social services information including communications made by me to a social worker, therapist, or psychologist.

It is futher understood that the information released is for the specific purpose stated above and may not be provided in whole or part to any other agency, organization, or person. I further understand that correspondence, patient discharge instructions, and records from healthcare providers other than Gastroenterology Consultants PLC may be released unless specifically requested otherwise.

This consent may be revoked at any time by writing to the address above, except for any action that has already been taken in reliance upon it.
Expired Date _____ or Action _____
If no express revocation is issued this authorization will expire 90 days from the date signed.

I understand that Health Information that is released under this Authorization may be subject to re-disclosure by the recipient and the privacy of my Health Information may no longer be protected by the law.

A FAX COPY OF THIS AUTHORIZTAION SHALL HAVE THE SAME EFFECT AS THE ORIGINAL*

_____ _____ _____
Signature of patient or Legal Representative Date Relationship