Midwest GI Health

MEDICAL RECORDS RELEASE

PATIENT'S NAME:_____ **DATE OF BIRTH:**_____

THE UNDERSIGNED AUTHORIZES AND REQUESTS FOR MIDWEST GI HEALTH

[ ] TO RELEASE TO: [ ] TO OBTAIN FROM: [ ] TO EXCHANGE VERBAL INFORMATION WITH:

FACILITY:_____

STREET ADDRESS:_____

CITY AND STATE:_____ ZIP:_____

THE FOLLOWING
INFORMATION:_____

THIS INFORMATION MAY BE DISCLOSED TO AND USED BY THE FOLLOWING INDIVIDUAL OR ORGANIZATION:

PROVIDER:_____

STREET ADDRESS:_____

CITY AND STATE:_____ ZIP:_____

FOR THE PURPOSE OF:_____

PHONE:_____ **FAX:**_____

ATTENTION:_____

I UNDERSTAND THAT MY MEDICAL RECORDS (INCLUDING ANY PSYCHIATRIC, ALCOHOL, OR DRUG ABUSE INFORMATION) MAY BE PROTECTED BY FEDERAL REGULATIONS. I ALSO UNDERSTAND THAT I MAY REVOKE THIS CONTENT AT ANY TIME EXCEPT TO THE EXTENT THAT ACTION HAS BEEN TAKEN IN RELIANCE ON IT (E.G. PROBATION, PAROLE, ETC.) AND THAT IN ANY EVENT, THIS CONSENT EXPIRES AUTOMATICALLY AS DESCRIBED BELOW. "I UNDERSTAND THAT MY RECORDS MAY CONTAIN INFORMATION REGARDING THE DIAGNOSIS OR TREATMENT OF HIV, (AIDS VIRUS), OR OTHER SEXUALLY TRANSMITTED DISEASES, DRUG AND/OR ALCOHOL ABUSE, MENTAL ILLNESS OR PSYCHIATRIC TREATMENT. I GIVE MY SPECIFIC AUTHORIZATION FOR THESE RECORDS TO BE RELEASED."
CONSENT GOOD FOR ONE (1) YEAR FROM DATE OF PATIENT'S SIGNATURE. I UNDERSTAND THAT I HAVE THE RIGHT TO REVOKE THE AUTHORIZATION IN WRITING EXCEPT TO THE EXTENT OFFICE/HOSPITAL HAS TAKEN ACTION OR HAS RELIED ON THE AUTHORATION. THIS AUTHORATION MAY BE REVOKED BY MY REQUESTING REVOCATION IN WRITING AND DELIVERING A COPY OF THE SAME TO OFFICE/HOSPITAL. THE INFORMATION USED OR DISCLOSED UNDER THE AUTHORATION MAY BE SUBJECT TO REDISCLOSURE BY THE RECIPIENT AND NO LONGER PROTECTED BY FEDERAL PRIVACY LAWS.

____/____/____
DATE

_____
(PATIENT'S SIGNATURE)

____/____/____
DATE

_____
(PATIENT'S GUARDIAN'S SIGNATURE OR
PATIENT'S AUTHORIZED REPRESENTIVE)

____/____/____
DATE

_____
(WITNESS)

REV 8 1/18