PROVIDENCE GASTROENTEROLOGY

Phone (248) 662-4110 | Fax (248) 662-4120
26850 Providence Parkway, Suite 350, Novi, MI 48374

Authorization for Release of Medical Information

Patient Name:_____ **Date of Birth:**_____

I authorize the physician listed below to release all information contained in my patient records, including as applicable: Please initial

_____ ☑ Information about human immunodeficiency virus (HIV), Acquired immunodeficiency syndrome (AIDS), and AIDS related complex (ARC).
_____ ☑ Alcohol and drug abuse treatment information protected under the regulations in 42 codes of Federal Regulations, Part 2.
_____ ☑ Mental Health treatment records, and psychological services and social services information including communications made by me to a social worker or psychologist.

OUR OFFICE TO RECEIVE RECORDS OUR

I authorize _____
Phone _____
Fax _____
to release to:

☐ MARK S. DEVORE, MD
☐ MICHAEL PIPER, MD
☐JULIA S. GREER, M.D.
☐BRADLY WARREN, D.O
☐KHA H. NGO, D.O.
☐SERGE A. SORSER, M.D
☐ RACHELLE PACKEY, PA
☐ TARA KARMO, PA.
☐SUSAN WOSIK, PA

OFFICE TO SEND OUT RECORDS

I authorize
☐ MARK S. DEVORE, MD
☐ MICHAEL PIPER, MD
☐JULIA S. GREER, M.D.
☐BRADLY WARREN, D.O
☐KHA H. NGO, D.O.
☐SERGE A. SORSER, M.D
☐ RACHELLE PACKEY, PA
☐ TARA KARMO, PA.
☐SUSAN WOSIK, PA

to release records to: (name & receiver of information)_

_____

_____

Public Act 47 of 2004 applied specific fees for patient records.
2016 MI Medical Records Access Act Fees (CY 2017) Fees may apply

Specific type of information to be disclosed:

☑ check box	Type of information	Dates from	Date to
☐	LAB WORK		
☐	X-RAYS		
☐	ENDOSCOPY REPORTS		
☐			

The purpose for this disclosure is for continuation of care. This consent can be revoked at any time unless the organization or individual from whom the records are being requested has acted in reliance upon its continued effectiveness. Regarding substance abuse treatment records, if any, this consent can last only long enough to reasonably accomplish its purpose. Without expressed revocation, this consent expires after 90 days or for the following specified reasons: _____

Patient Signature _____Date _____

Witness Signature _____ Date _____