AUTHORIZATION TO RELEASE MEDICAL RECORDS

Digestive Disease Consultants/Oakland Digestive Diseases PLLC
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Pontiac, MI 48341
Phone: (248) 858-3878
FAX: 248-209-6777

I, _____, DOB:_____,
Hereby authorize Digestive Disease Consultants to release / receive information contained in my medical record to / from:

Name: _____
Attn: _____
Address: _____
_____
Phone: _____
Fax: _____

SPECIFIC INFORMATION TO BE DISCLOSED:

- Office Notes_____
- Labwork _____
- Radiology _____
- O.P. Notes _____
- Pathology _____
- Complete Medical Record_____

Records released to self:_____

Records released to Brian Markle MD _____
Mones Takriti M.D. _____

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to our practice. We may have already released the information based on your original authorization. We will not release any additional information after we receive your revocation. We will not condition treatment or payment based on this authorization or revocation of authorization unless otherwise allowed by law. Your protected health information will be disclosed as specified in this authorization. This authorization will expire 120 days from the date of signature, or until we have completed the disclosure(s) you've requested, whichever is shorter. This information could be subject to re-disclosure by the recipient and may then no longer be protected.

Signature of Patient / Parent of Minor / or Representative:

_____Date: _____

Witness: _____Date: _____