ENDOSCOPIC SOLUTIONS, P.C.
GASTROENTEROLOGY | Clarkston, MI • Oxford, MI • 248-625-4055 | Fax 248-625-4085

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

HIPAA Authorization under 45 CFR § 164.508 · Distinct from a Patient Request for Records (Appx J-1)

1. PATIENT INFORMATION

Full Legal Name _____ **Date of Birth** _____ **MRN# (if known)** _____

Address _____ **Phone** _____

2. INFORMATION TO BE RELEASED

- ☐ Complete medical record
- ☐ Office visit notes only
- ☐ Procedure / endoscopy reports
- ☐ Pathology / lab results
- ☐ Imaging studies
- ☐ Billing records / itemized statements
- ☐ Records from specific date(s):
- ☐ Other:

Date range or "other" details _____

Special-category records (mental health, psychotherapy notes, substance-use treatment under 42 CFR Part 2, HIV/AIDS, genetic information, STI records) require separate written authorization for each category — ask the Privacy Officer before completing this form if any of those apply.

3. AUTHORIZED TO RELEASE

Pre-populated:

Endoscopic Solutions, PC
5701 Bow Pointe Drive, Suite 370
Clarkston, MI 48346
(248) 625-4055 · Fax (248) 625-4085

4. AUTHORIZED TO RECEIVE

Name _____
Organization _____
Address _____
City/ST/ZIP _____
Phone _____ **Email/Fax** _____

5. PURPOSE OF RELEASE

"At the patient's request" is acceptable.

_____

6. EXPIRATION (an authorization with no expiration is not valid)

- ☐ On the date: _____
- ☐ Upon event: _____
- ☐ One year from signing (default if none specified)

7. PATIENT RIGHTS & ACKNOWLEDGMENTS (REQUIRED — read before signing)

- I may revoke this authorization at any time by written notice to the Privacy Officer. Revocation does not apply to information already released in reliance on this authorization.
- Treatment, payment, enrollment in a health plan, or eligibility for benefits CANNOT be conditioned on whether I sign this authorization.
- Information released under this authorization may no longer be protected by federal privacy law once received and may be subject to re-disclosure by the recipient.
- I may inspect or copy the information released; I will receive a copy of this signed authorization.

8. SIGNATURE

_____ _____ _____
Patient (or Personal Representative) Signature **Date** **Printed Name**

If signed by Personal Representative, describe authority: _____