DIGESTIVE HEALTH CENTER OF MICHIGAN
DHCMI

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AUTHORIZATION TO RELEASE/REQUEST MEDICAL RECORDS INFORMATION

TO: RONALD FOGEL, M.D. OR YAKIR MUSZKAT, M.D.
30795 23 MILE ROAD., SUITE# 206
CHESTERFIELD TOWNSHIP, MI 48047

PHONE: 586-598-5731
FAX: 586-948-1530

I hereby authorize the above listed entity to ☐ RELEASE ☐ RECEIVE my protected health information

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

Address (street, city, state, zip code) _____ **Telephone number:** _____

Requested Dates of Service: _____ **Purpose of request:** *To CoordinateMedicalTreatment*

The following information is being requested:

☐ Complete record	☐ Cardiac	☐ X-Ray Reports
☐ Physician/Office Notes	☐ Tests	☐ History/Physical
☐ Labs	☐ EGD/Colonoscopy	☐ Pathology Reports

Sensitive information: I understand that the information in my record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or infrection with the Human Immunodeficiency Virus (HIV). It may also include information about behavioral or mental health services or treatment for alcohol and drug abuse unless indicated below.

☐ I do not authorize the release of records regarding HIV infection, AIDS related Complex, and/or serious communicable diseases.
☐ I do not authorize the release of records regarding drug/alcohol abuse.

Redisclosure: I understand that I have the right to revoke this authorization at any time. I understand that my revocation must be in writing. I understand that the revocation will not apply to information already released based on this authorization.

Other Rights:

a) I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form to assure treatment. However, if this authorization is needed for participation in a research study, my enrollment in the research study may be denied.

b) I understand that I may inspect or obtain a copy of the information to be used or disclosed.

Signature of Patient or Legal Representative/Date:	Witness Signature/Date:

If Signed by legal representative, relationship to patient: _____