Troy Gastroenterology, P.C.

And its Affiliated Covered Entities: Center for Digestive Health, Macomb Endoscopy Center, and Surgical Centers of Michigan

HIPAA Authorization for Disclosure of Protected Health Information

At times we may need to contact you about test results, appointments, referrals or billing/insurance information. In an effort to better serve you, protect your privacy and follow federal guidelines, please consider the following:

List family members and/or other persons, if any, whom we may inform about your general medical condition and your diagnosis, including treatment, payment and health care operations. Do not list your physician in this section. *We will only provide the minimum amount of information necessary.*

Name _____ Phone Number _____ Leave Voicemail YES NO

Address _____ Relationship to Patient: _____

Name _____ Phone Number _____ Leave Voicemail: YES NO

Address _____ Relationship to Patient: _____

Name _____ Phone Number _____ Leave Voicemail: YES NO

Address _____ Relationship to Patient: _____

If you do not want our office to discuss any portion of your medical care or financial information with anyone but you, please initial on this line_____ (Release to Self Only).

Expiration Date of Authorization:
This authorization is effective for ***one year*** unless revoked or terminated earlier by the patient or the patient's representative.

Right to Terminate or Revoke Authorization
You may revoke or terminate this authorization by submitting a written letter to Troy Gastroenterology. You should contact the HIPAA Officer at 1701 E. South Blvd, Suite 300, Rochester Hills, Michigan 48307 to terminate this authorization.

Treatment, Payment or Operations
Treatment, payment, enrollment or eligibility for benefits may not be conditioned on obtaining this authorization if such conditioning is provided by the Privacy Rule.

Potential for Redisclosure
Any disclosure information carries with it the potential for unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

Rights of the Individual
- You may inspect or request a copy of information that is used or disclosed under this authorization.
- You may refuse to sign this authorization.

Effect of Refusing Authorization
If you refuse to sign this authorization, Troy Gastroenterology will not deny you any treatment except research-related treatment or treatment that you have requested for the purpose of disclosure to others.

Please note: While we may ask you from time to time if there have been any changes to this information, it is your responsibility to update this information as needed.

_____ _____
Patient Name (please print) Date of Birth

_____ _____
Signature of Patient/Patient Representative Date Signed

_____
Relationship of Patient Representative to Patient