Thirlby Clinic
3537 West Front St. Ste I
Traverse City, MI 49684
P:231-935-8950 F:231-935-8868

Authorization for use and disclosure of Protected Health Information

I, _____ Date of Birth:_____, authorize the disclosure of my Protected Health Information. I understand that this authorization is voluntary and made to confirm my direction.

☐ **Secure email to the following address:** _____

****I understand that by requesting my medical records via Ciox eDelivery, I must provide a valid email address, either my own or that of my designated recipient. My records will be provided as Adobe PDF files on Ciox's eDelivery website. I will receive an email from eDelivery.com containing instructions for accessing my records. There may be a fee for collecting my records. If so, an invoice will be included with the records.**

Purpose of Disclosure/Release: ___ Continuation of Care ___ Transition of Care ___ Other

I Hereby Authorize:	To Release My Records To:
Name:_____	Name: _____
Address:_____	Address:_____
_____	_____
Phone:_____	Phone:_____
Fax:_____	Fax:_____

Information to be release (please initial):

- ____ Entire medical record (this is most often for New Patients only)
- ____ Health care information relating to the following treatment condition(s):
  - Most recent colonoscopy
  - Most recent pap/HPV
  - All abnormal results for: _____
  - Radiology report for: _____
- ____ Health information in my record for: ___ last 12 months ___ last 2 years dates:_____

I specifically DECLINE the release of information relating to (please initial):

____ I decline release of Substance Abuse records (including alcohol, drug and prescription medications)

____ I decline the release of Mental Health or Behavioral Health records

____ I decline the release of HIV/AIDS information

Code 42 of Federal Regulation of the HIPAA and Michigan, Dept of Public Health Act (Public Act 174,1989)

ACKNOWLEDGEMENT OF UNDERSTANDING: By signing the completed form, I hereby certify that I am acknowledging my consent is given freely and voluntarily. I am certifying that I understand the following:

- This authorization will expire 90 days from the date signed unless otherwise noted here _____
- I may revoke this authorization at any time by notifying the providing organization in writing and it will be in effect upon the date of notification, unless the record transaction is already in action.
- The information used or disclosed following this authorization may be subject to re-disclosure by the recipient and no longer protected by Federal privacy regulations.
- I understand that in accordance with Michigan law, I may be charged a fee for preparing and sending copies except for uses and disclosure for the purpose of treatment and operations. The fee will not exceed the current state limits.

Patient or Guardian Signature Date

Patient Name and Relation to Patient