Protecting Patient Protected Health Information (PHI) is a way that we respect patient information and privacy. Please follow the directions below to use the attached form.

If you are a **Patient** wishing to obtain your own records:

To obtain a copy of your medical records from Great Lakes Bay Surgery & Endoscopy Center, please follow the instructions listed below:

1. Print out this document and complete the Authorization for Release of Information form, leaving the witness signature line blank.
2. Please bring the completed form and a copy of your ID with you to Great Lakes Bay Surgery & Endoscopy Center.
3. If you are unable to return the completed form in-person, please mail the completed form with a photocopy of your ID to the address below and your records will be mailed to you promptly:

Great Lakes Bay Surgery & Endoscopy Center at: 4228 Bay City Rd. Midland, MI 48642

If you are a **Patient** wishing to send your own medical record directly to another medical provider; please have that provider FAX a request to 989-495-9150.

If you are a **Medical Provider** requiring a copy of a patient medical record**:**

Please FAX us your request on your letterhead; 989-495-9150.

If you are an **insurance company, legal representative, or government agency** you may mail or FAX a request.

If you have any questions, please call 989-495-9100 and select the Medical Records option. Office hours are 7:30am – 3:30pm.

RELEASE OF MEDICAL INFORMATION AUTHORIZATION

Patient Name:____Date of Birth: _____________

Maiden Name: ____

Address:______________________________City: _______________________State:________ Zip:_________

Phone Number:____________________________________Last 4 Digits of SS # (optional):_______

RECORD RELEASE

I authorize my records to be sent FROM:

Name/Organization:____

Address:______________________________City: _______________________State:________ Zip:_________

Phone Number:____________________________________Fax Number:________________________________

I authorize my records to be released TO:

Name/Organization:____

Address:______________________________City: _______________________State:________ Zip:_________

Phone Number:____________________________________Fax Number:________________________________

Method of Release:

- ☐ Medical Records to be Picked Up (Please provide Phone # above)
- ☐ Medical Records to be Mailed (Please provide address above)
- ☐ Medical records to be Faxed (Please provide Fax # above)

INFORMATION REQUESTED

- ☐ Complete Record
- ☐ Abstract Record
- ☐ Discharge Summary / Instructions
- ☐ History & Physical
- ☐ Pathology Reports
- ☐ Procedure Reports
- ☐ Other (specify)____

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Date(s) of Service:__________________________

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PURPOSE OF DISCLOSURE

- ☐ Patient Request
- ☐ Attorney/Legal
- ☐ Insurance
- ☐ Continued Patient Care
- ☐ Other (specify)____

Include: (Indicate by Initialing)

__________Alcohol/Drug Treatment ____________Mental Health Information

__________HIV-Related Information _____________ Genetic Testing

I understand that patient discharge instructions and records from other health care providers may be released with this routine request. I also acknowledge that Great Lakes Bay Surgery and Endoscopy Center assumes no responsibility or liability for the accuracy or legitimacy of any records originating with a non-GLBS health provider. There is potential that information disclosed under the authorization may be disclosed by the recipient and may no longer be protected by Federal Health Insurance Portability and Accountability Act (HIPAA). However, if information under any of the protected categories identified above is released in accordance with this authorization, any re-release of that information may not be allowed under law. This includes the Michigan Mental Health code (sections 748, 749 and 750 of the Public Act 258 of 1974 as amended) and Title 42 of the Code of Federal Regulations, Part II. In that case, the information may not be copied, shared or re-released by the recipient, except as consistent with the stated purpose authorized in this form. This authorization may be revoked in writing at any time. Great Lakes Bay Surgery and Endoscopy Center does not require this authorization as a condition for giving treatment, payment enrollment or eligibility for benefits. This authorization will expire ninety (90) days from the date of my signature, unless I specify otherwise below:
_______________________________________.

Patient Signature:________________________________Date:_______________Time:_______________

Legal Guardian/Representative Signature:________________________________Date:_______________
Time:_______________

Witness Signature:________________________________Date:_______________Time:_______________

Please contact GLBS Medical Records with any questions at 989-495-9100 ext. 122