

Capital Internal Medicine Associates, P.C.

*A New Beginning OB/GYN *CIMA Acute Bridging Clinic *CIMA Breast Center *CIMA Heart Institute
*CIMA Main Office *CIMA Primary Care * Haslett Primary Care *Kozmic Family Practice
*Mason Internal Medicine *Williamston Primary Care

**3955 Patient Care Dr. Suite A
Lansing, MI 48911**

Phone: (517) 374-7600 Fax: (855) 505-8064

Authorization for Use or Disclosure of Information

*Patient Name: _____ *Maiden/Other Name _____

*D.O.B. ____/____/____ *Phone Number (____) _____

*Patient Address _____
Street City State Zip

I authorize _____
Healthcare facility/physician

To release any and all information contained in the record which may include information regarding: **Drug and/or alcohol treatment, psychological records, HIV/AIDS and other Sexually Transmitted Disease.**

Name to whom information may be released: _____
Physician/Facility

*Please send most recent:

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> Emergency Room Records | <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Colonoscopy | <input type="checkbox"/> Operative Reports |
| <input type="checkbox"/> Radiology/Diagnostic Reports | <input type="checkbox"/> Laboratory Reports | <input type="checkbox"/> Pathology Reports | <input type="checkbox"/> Clinic Notes |
| <input type="checkbox"/> Radiology/Diagnostic Imaging | <input type="checkbox"/> Medications | <input type="checkbox"/> Immunizations | <input type="checkbox"/> Billing Records |
| <input type="checkbox"/> Entire Medical Record | <input type="checkbox"/> Other (Specify): _____ | | |

*Information to Be Released (From Date: _____ To Date: _____)

This authorization expires (Date): _____ (if no date is given this release will expire one year from date of patient's signature)

I understand that, as set forth in the practice's Notice of Privacy Practices, I have the right to revoke this authorization, in writing, at any time by sending written notification.

I understand that a revocation is not effective to the extent that the practice has relied on the use or disclosure of the protected health information.

Signature of Patient or Personal Representative Date

Printed Name of Patient or Personal Representative (if necessary)

Person Authorized to Pick-up on Patient's Behalf

This form for Authorization for Use or Disclosure of Information is designed to comply with Title 42 of Federal Regulations, Part 2 (HIPAA).

The Group Health Plan within the Capital Internal Medicine Associates,
PC Employee Benefits Plan complies with applicable Federal civil rights laws
and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Spanish	ATENCIÓN:	si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-517-374-7600.
Arabic	ملحوظة:	بإرفاق اتصال بالمجان لك تتوافر اللغوية المساعدة خدمات فإن، اللغة اذكر تحدث كنت إذا 1-517-374-7600