Capital Internal Medicine Associates, P.C.

*A New Beginning OB/GYN *CIMA Breast Center *CIMA Heart Institute
*CIMA Main Office *CIMA Primary Care * Haslett Primary Care *Kozmic Family Practice *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/Self

***Please send most recent:**

☐ Entire Medical Record ☐ Discharge Summary ☐ Colonoscopy ☐ Operative Report
(5 Years of Records provided, unless otherwise specified)

☐ Radiology/Diagnostic Reports ☐ Laboratory Reports ☐ Pathology Reports ☐ Progress Notes

☐ Radiology/Diagnostic Imaging ☐ Medications ☐ Immunizations ☐ Billing Records

☐ Emergency Room Records ☐ Other (Specify): _____

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

Here at CIMA we are constantly trying to improve our quality of care, if you are leaving the practice please give a brief description as to why: (optional) _____

_____

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:	إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-517-374-7600

REV 9-2020