North Coast Endoscopy, Inc.
9500 Mentor Avenue Suite 380
Mentor, OH 44060
440-352-9400

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Patient's Full Name: _____ DOB: __/__/__ Today's Date:__/__/__

Transfer of care □ Continuation of care □ Other: _____

This authorization is required by the Health Insurance Portability and Accountability Act of 1976 to inform you of your rights for privacy with respect to your health care information. It authorizes Ahmad Ascha, MD to disclose my medical records relating to:

ALL □ LAB □ XRAYS □ ENDOSCOPIES □ NOTES □ PATHOLOGY □

Others (specify)_____

From Date: _____ / _____ / _____ To Date:_____ / _____ / _____

To be released to the following entity:

Name_____
Address_____
City_____State_____Zip_____

Under the privacy rules I have the right to revoke this authorization at any time in writing and Ahmad Ascha, MD must cease using this authorization. However, Ahmad Ascha, MD may complete any actions it initiated with my PHI prior to my revocation.

I understand that by disclosing these records, which contain Highly Confidential Medical Information, Ahmad Ascha, MD cannot guarantee the recipient will not re-disclose or use the records in violation of the Privacy Rules.

I must revoke this authorization in writing to: Ahmad Ascha, MD

Patient/Guardian_____ Date ____ / ____ / ____

Name Printed:_____
If not patient, relationship_____

Witness:_____ Date ____ / ____ / ____

Name Printed:_____

I am also aware that effective March 2001, the State of Ohio HB 508 (with few exceptions) allows a fee of $15.00 to retrieve this medical record and an additional fee of $1.00 per page up to the first 10 pages, and $0.50 per page for 11-50 pages.

Records Reviewed:_____ Sent: _____ By: _____

Fee Charged/Collected:_____