PATIENT HIPPA CONSENT FORM

The Department of Health and Human Services has established a "Privacy Rule" to help ensure that personal health care information is protected. This rule mandates the health care providers to obtain their patients' consent for uses and disclosure of health information.

We will do all we can to secure and protect the privacy of your personal records. When it is appropriate and necessary, we will provide requested information – but only to those who are in need of it in order to facilitate and promote your current health care issue resolution.

You may refuse to consent to disclosure of the information. Under the law, we have the right to refuse to treat you if you chose to exercise this option. You may also request the termination of information sharing at a later date (completely or in part). Any revocation of such consent must be done in writing. You may not revoke actions that have already been taken by relying on the previously signed consent. All consents expire after 3 years of medical inactivity. The full text of HIPPA Notice is readily available upon request.

All medical records are destroyed after 7 (seven) years of *medical* inactivity.

You signature authorizes the receipt and/ or release of necessary information. You signature also acknowledges the understanding of Friedman Surgical Group, P.C. HIPPA policy as applicable to you and your care.

MEDICAL RECORDS RELEASE FORM

Pt NAME _____ DOB _____

RECORDS REQUESTED

NAME OF PERSON/ FACILITY _____

PRACTICE ADDRESS _____

PHONE _____ FAX_____

Please disclose the following records to: Friedman Surgical Group, PC

14555 Levan Rd, Suite 307, Livonia, MI 48154

Phone 734.462.1525 Fax 734.462.1830

Please select as applicable

___ clinic/ progress notes **___ Pathology/ other lab reports**

___ History & Physical/ Discharge Summary **___ operative reports**

___ Radiology report **other _____**

X_____ Date _____

Revised: 04/30/2020