North Coast Endoscopy, LLC.
9500 Mentor Avenue Suite 340
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/Emily Carey,DO 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_____
Phone_____ Fax_____

Under the privacy rules I have the right to revoke this authorization at any time in writing and Ahmad Ascha, MD/Emily Carey, DO must cease using this authorization. However, Ahmad Ascha, MD/Emily Carey, DO 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/Emily Carey, DO 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/Emily Carey, DO

Patient/Guardian_____ Date ____ / ____ / ____

Name Printed:_____
If not patient, relationship_____

Witness:_____ Date ____ / ____ / ____

Name Printed:_____

PATIENT REQUEST:
Search Fee- $0
$3.31 per page for the first 10 pages
$0.69 per page for pages 11-50
$0.28 cents per page for pages 51 and over

PROVIDER REQUEST:
Search Fee: $20.42
$1.34 per page for the first 10 pages
$0.69 for pages 11-50
$0.27 for pages 51 and over

Records Reviewed:_____ Sent: _____ By: _____Fee Charged/Collected:_____ Patients signature & date records were hand delivered:_____

MEDICAL RECORD REQUESTS CAN TAKE UP TO 30 DAYS TO PROCESS.