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**BRONSON LAKEVIEW HOSPITAL**  
**P.O. BOX 209 408 HAZEN STREET PAW PAW, MI 49079-0209**  
**(269) 657-3141**

**AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION**

Patient's Name: \_\_\_\_\_ Medical Record No.: \_\_\_\_\_

Birth Date: \_\_\_\_\_

Hospitalization Date(s): \_\_\_\_\_ Acct. No.: \_\_\_\_\_

(Please specify whether inpatient, clinic, emergency department, etc.)

- I authorize the use or disclosure of the above named individually identifiable health information as described below. I understand that the information I authorize another person or entity to receive may be redisclosed by the person or entity, and may no longer be protected by federal privacy regulations.
- The following individual or organization is authorized to make the disclosure:

Address \_\_\_\_\_

- The type and amount of information to be used or disclosed is as follows: (Include dates where appropriate.)

**INFORMATION REQUESTED**

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Face Sheet        | <input type="checkbox"/> Pathology Reports      | <input type="checkbox"/> Social History           |
| <input type="checkbox"/> Physician Orders  | <input type="checkbox"/> Consultation(s)        | <input type="checkbox"/> Psychological Reports    |
| <input type="checkbox"/> Progress Notes    | <input type="checkbox"/> Laboratory Reports     | <input type="checkbox"/> Neurological Studies     |
| <input type="checkbox"/> History/Physical  | <input type="checkbox"/> EKG Interpretations    | <input type="checkbox"/> Treatment Plan & Reviews |
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> X-ray Reports          | <input type="checkbox"/> Copy of Entire Record    |
| <input type="checkbox"/> Medication Record | <input type="checkbox"/> Psychiatric Evaluation | <input type="checkbox"/> Other – Please specify:  |
| <input type="checkbox"/> Operative Reports | <input type="checkbox"/> Rehab. Assessment      |   |

- I understand that the information in my health record may include any information concerning treatment for psychiatric illness, alcohol and/or drug abuse protected under the regulations in 42 Code of Federal Regulations, HIV test results, diagnosis of AIDS, or AIDS related condition, respecting the above hospitalization dates to the individual(s) or organization(s) listed below.
- The information may be disclosed to and used by the following individual or organization:

Address & Phone: \_\_\_\_\_

for the purpose of \_\_\_\_\_

- Marketing – This authorization does not permit the use and disclosure of health care information for marketing purposes.
- I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Health Information Management Department. However, the revocation will not be valid to the extent that Bronson LakeView Hospital has taken action in reliance on this authorization or to the extent this authorization is executed as a condition for obtaining insurance coverage.
- This authorization expires on (upon): \_\_\_\_\_  
[Insert Applicable Date or Event]
- I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment, however if the purpose for my treatment is solely to produce information for a third party, LakeView Community Hospital may require an authorization to release information to that third party as a condition to rendering the treatment.
- A photocopy of this authorization is to be accepted the same as the original.

\_\_\_\_\_  
Signature of Patient or Legal Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
If signed by a Legal Representative, Relationship to patient

\_\_\_\_\_  
Signature of Witness

**Please Circle Appropriate Area:** FAXED/MAILED/PATIENT PICK-UP      FAXED TO #: \_\_\_\_\_

COPIED BY (Name/Department/Date): \_\_\_\_\_

**ANY RE-DISCLOSURE OF MEDICAL INFORMATION BY THE RECIPIENT IS PROHIBITED.**