BRONSON

For Office Use Only

Affix Patient Label or MRN: _____

Request for Access or Authorization for Use and Disclosure of Protected Health Information

Patient Name: _____ Birthdate: _____
Last First Middle Initial month/day/year

Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____

I give permission to:

☐ **Bronson Battle Creek**
300 North Avenue
Battle Creek, MI 49017
Phone: (269) 245-5851
Fax: (269) 341-6528

☐ **Bronson Behavioral Health**
165 N. Washington Avenue
Battle Creek, MI 49037
Phone: (269) 245-5851
Fax: (269) 341-6528

☐ **Bronson LakeView Hospital**
408 Hazen Street
Paw Paw, MI 49079
Phone: (269) 657-1465
Fax: (269) 341-6528

☐ **Bronson Methodist Hospital**
601 John Street, Box F
Kalamazoo, MI 49007
Phone: (269) 341-6487
Fax: (269) 341-6528

☐ **Bronson Physician Offices**
Office: _____
Physician: _____
Phone: (269) 341-6487
Fax: (269) 341-6528

☐ **Bronson South Haven**
955 S. Bailey Avenue
South Haven, MI 49090
Phone: (269) 637-5271 ext. 2293
Fax: (269) 341-6528

To release my health information to the following by (circle): **Fax / Mail / Pick Up** (Location) _____

Name of individual or agency: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____ Fax Number: _____

Information to be released:

Dates of Service: _____

- ☐ Behavioral Health Records
- ☐ Cardiac Records
- ☐ Consults
- ☐ Discharge Summary
- ☐ Emergency Room Records
- ☐ History & Physical
- ☐ Lab Reports
- ☐ Medication Records
- ☐ Neurodiagnostics Records
- ☐ Operative Record
- ☐ Office Notes
- ☐ Pathology Report
- ☐ Progress Notes
- ☐ Radiology Images-CD
- ☐ Radiology Reports
- ☐ Other (specify content and dates): _____

Purpose of Disclosure:

- ☐ Continuing Care
- ☐ Personal Use
- ☐ Other (specify): _____
- ☐ Insurance or Worker's Compensation
- ☐ Legal

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I authorize the release of health information, contained in my medical records including:

- Information regarding communicable diseases and infections, as defined by statute and Michigan Department of Health rules, which include venereal disease, Tuberculosis, Hepatitis A, B, C, Human Immunodeficiency virus (HIV), HIV testing.
- Acquired Immunodeficiency Syndrome (AIDS), and AIDS related complex (ARC).
- Alcohol and drug abuse treatment information protected under the regulations in CFR 42, Part 2
- Mental health treatment records, psychological services and social services information including communications made by me to a social worker, therapist, or psychologist.

Acknowledgement of Understanding:

- I understand this authorization will expire in one year from date signed.
- I can cancel this authorization at any time by writing to Bronson Healthcare Group (BHG).
- It will take effect on the date notified, except if action has already been taken.
- I understand that if I release my medical record to a person or provider, they can release my medical record. I know I need to check with them about their privacy rules.
- I will get an abstract of my medical record unless I ask for the complete record.
- No conditions will be placed on me if I sign this form.

Michigan law says I may have to pay for:

- Copies of my record
- Inspection of my record
- Written summary of findings

Bronson Healthcare Group will not benefit from disclosing this information.

Patient Signature: _____ Date: _____ Time: _____

Relationship: ☐ **Patient** ☐ **Parent** ☐ **Personal Representative** ☐ **Guardian**

☐ **DPOA (Durable Power of Attorney for Healthcare) (copy of DPOA required)**

☐ **Legal Next of Kin** _____ **Relationship** _____

Interpreter's Statement: I have interpreted the text on this form to the patient, a parent, closest relative or legal guardian.

Interpreter's Signature: _____ ID #: _____ Date: _____ Time: _____

Signature of BHG Personnel: _____ Date: _____ Time: _____

☐ **Mailed** ☐ **Picked Up** ☐ **Faxed to:** _____

TO BE RETAINED AS PART OF THE PERMANENT RECORD