BRONSON

Affix Patient Label

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

PATIENT NAME: _____ BIRTHDATE: _____
Last First Middle Initial month/day/year

ADDRESS: _____
Street Apartment Number City State Zip

PHONE NUMBER _____

I give permission to

☐ **Bronson Battle Creek**
300 North Avenue
Battle Creek, MI 49017
Phone 269-245-5851
Fax: 269-245-5875

☐ **Bronson Behavioral Health**
165 N. Washington Avenue
Battle Creek, MI 49037
Phone 269-245-5851
Fax: 269-245-5875

☐ **Bronson Methodist Hospital**
601 John Street Box F
Kalamazoo, MI 49007
Phone 269-341-6487
Fax 269-341-6294

☐ **Bronson LakeView Hospital**
408 Hazen Street
Paw Paw, MI 49079
Phone: 269-657-1465
Fax 269-657-1349

☐ **Bronson South Haven**
955 S. Bailey Avenue
South Haven, MI 49090
Phone: 269-637-5271 extension 2293
Fax: 269-639-2969

To release my health information to the following:

Name of individual or agency: _____

Address: _____

City: _____ State: _____ Zip _____

Phone Number _____ Fax Number _____

Information to be released

Dates of Service _____

- ☐ Admission Evaluation
- ☐ Cardiac Records
- ☐ Consults
- ☐ Discharge Summary
- ☐ History & Physical
- ☐ Lab Reports
- ☐ Medication Records
- ☐ Neurodiagnostics Records
- ☐ Operative Record
- ☐ Pathology Report
- ☐ Progress Notes
- ☐ Psychiatric Admission History
- ☐ Radiology Images-CD
- ☐ Radiology Reports
- ☐ Other (specify content and dates) _____

Purpose of Disclosure

- ☐ At request of individual _____
- ☐ Changing doctors
- ☐ Continuing Care
- ☐ For my own use
- ☐ Insurance or Worker's Compensation
- ☐ Legal
- ☐ Research
- ☐ School
- ☐ Other (specify) _____

General Authorization for Use or Disclosure of Health Information

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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

_____ _____ _____

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 to patient)

_____ _____ _____

Signature of BHG Personnel Date Time

☐ Mailed ☐ Picked up ☐ Faxed to_____

TO BE RETAINED AS PART OF THE PERMANENT RECORD

Charge amount:	√ If no charge to patient
$	

General Authorization for Use or Disclosure of Health Information