AUTHORIZATION FOR DISCLOSURE OF PATIENT MEDICAL INFORMATION

I, _____, hereby authorize:
Patient's Name

Beaumont Health System
☐ 3601 W 13 Mile Rd, Royal Oak MI 48073-6769
☐ 44201 Dequindre Rd, Troy MI 48085-1198
☐ 468 Cadieux Rd, Grosse Pte. MI 48230-1507

OR Other: _____
Name of person or organization releasing information
Address:

Its Director or designee, or Medical Information Services Department to release information contained in my patient records, including alcohol and drug abuse records protected under the regulations in 42 Code of Federal Regulations, Part 2, if any, psychiatric/psychological services records, and if, any social work records, if any, including communications made by me to a social worker or psychiatrist/psychologist, and any information regarding communicable diseases and serious communicable diseases and infections as defined by Michigan Department of Public Health rule which can include venereal disease, tuberculosis, HIV, AIDS, or ARC, if any, to the individuals or organizations listed below, only under the conditions listed below:

PATIENT'S PHONE NUMBER (including area code)	BIRTHDATE OF PATIENT	PATIENT NUMBER

1. Person(s) or organization(s) to whom disclosure is to be made (indicate one):

NAME	PHONE (including area code)
ADDRESS	FAX (including area code)

2. Specify type of information to be disclosed: ***

Date _____ Date Through _____

☐ Discharge Summary
☐ Labs
☐ Radiology / X-Ray
☐ Cardiology (Specify)
☐ Nuclear Medicine
☐ Pertinent Copy (Dictated reports / diagnostic tests)
☐ Operative Reports
☐ Emergency Reports
☐ Complete Copy (Charges may apply)
☐ Other _____

3. The purpose and need for such disclosure, if requested by a person other than the patient or authorized representative.

☐ Continuation of Treatment or Health Care
☐ Insurance Investigation
☐ Disability Determination
☐ Vocational Rehabilitation
☐ Social Service Referral
☐ Billing Information

Other (specify) _____

4. Information to be ☐ Mailed ☐ Picked up ☐ Faxed (Doctor's Office & Hospitals only)
☐ Electronic Record Access employee ☐ Electronic Record Access *my*BeaumontChart
Last 4 digits of SSN _____

If pick-up is checked, by whom (name): _____
(If someone other than patient will pickup, include letter of authorization signed by patient or authorized representative.)

5. This authorization is subject to written revocation at any time except to the extent that Beaumont Health System has already taken action in reliance on the authorization. This authorization will expire upon disclosure of requested information or _____.

_____ Date _____
Signature of Patient / Parent of a minor / Authorized Representative

(If authorized representative signature, include paperwork). The date of the patient's or authorized representatives's signature on the Authorization Form must be NO more than 60 days before received. If the patient is currently an inpatient the record is not released until after discharge.

*** Beaumont Health System and / or its copying services reserve the right to charge for processing and copying information. This fee is waived when releasing pertinent information directly to a treating physician or health care facility.