BRONSON

Affix Patient Label

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

Patient Name:_____
Last First MI

Date of Birth:_____
Month Day Year

I give permission to Bronson Healthcare Group to use or disclose my protected health information indicated below to

NAME:_____

ADDRESS:_____ CITY:_____

STATE:_____ ZIP CODE:_____

PHONE:_____ FAX:_____

Information to be released:
(Please check boxes that apply)

- ☐ Discharge Summary
- ☐ History and Physical Exam
- ☐ Progress Notes
- ☐ Lab Reports
- ☐ X-Ray Reports
- ☐ Medication Records
- ☐ Detailed Bill

Other (specify content and dates)_____

Purpose of Disclosure:

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

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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 statue 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.
- 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 of Patient Date

_____ _____

Parent or Personal Representative Date