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

I give permission to _____
(Name of Individual or Agency)

To release my health information to the following:

☐ **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 ext. 2293
Fax: 269-639-2969

☐ **Bronson Center for Women**
601 John Street Suite M-515
Kalamazoo, MI 49007
Phone: 269-341-8432
Fax: 269-341-7914

☐ **Fax Medical Records to Unit:** Fax Number _____ Unit Phone Number _____

Information to be released

Dates of Service _____

- ☐ Admission Evaluation
- ☐ Cardiac Records
- ☐ Consults
- ☐ Discharge Summary
- ☐ History & Physical
- ☐ Lab Reports
- ☐ Mammography- *Please send available reports and images of breast related exams (including breast MRI and U/S exams) electronically. If unable to send images electronically, please mail DICOM-CD and fax corresponding report(s).*
- ☐ Medication Records
- ☐ Neurodiagnostics Records
- ☐ Operative Record
- ☐ Pathology Report
- ☐ Psychiatric Admission History
- ☐ X-Ray Reports
- ☐ Other (specify content and dates) _____

Purpose of Disclosure

- ☐ Continuing Care
- ☐ Other (specify) _____

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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 stature 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.

_____ _____ _____

Signature Date Time

Relationship: ☐ Patient ☐ Guardian ☐ DPOA (Durable Power of Attorney for Healthcare)

☐ Legal Next of Kin _____
(Relationship to patient)