AUTHORIZATION FOR DISCLOSURE OF PATIENT MEDICAL INFORMATION

I _____ , hereby authorize:
PATIENT'S NAME

NAME OF PERSON OR ORGANIZATION RELEASING INFORMATION

William Beaumont Hospital OR Other: _____
3601 W 13 Mile Rd, Royal Oak MI 48073-6769 ADDRESS
or
44201 Dequindre Rd, Troy MI 48085-1198

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 (include area code)	BIRTHDATE OF PATIENT	PATIENT NUMBER

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

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

2. Specific type of information to be disclosed:

Date _____ Date Through: _____

- ☐ Discharge Summary
- ☐ Labs
- ☐ X-Rays
- ☐ Other: _____
- ☐ Pertinent Copy
- ☐ Operative Reports
- ☐ Emergency Reports
- ☐ Other: _____

3. The purpose and need for such disclosure:

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

Other
(specify) _____

4. Information to be ☐ Mailed ☐ Picked up ☐ Faxed (Doctor's Office & Hospital's only)
If pick-up is checked, by whom _____
(If someone other than patient will pickup, include letter of authorization.)

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

Signature of Patient / Parent of a minor/ Authorized Representative _____ Date _____
(If authorized representative signature, include paperwork.)