

AUTHORIZATION FOR DISCLOSURE OF PATIENT MEDICAL INFORMATION

, 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
or
44201 Dequindre Rd, Troy MI 48098-1198

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 (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

**Examination Mgt Svcs Inc
654 Portage Trail Ste 4
Cuyahoga Falls OH 44221
330-923-8255**

FAX (include area code)

2. Specific type of information to be

Date From:

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.

If pick-up is checked, by whom (name):

(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

(If authorized representative signature, include paperwork.)

Date