BRONSON

Affix Patient Label	
Patient Name:	Date of Birth:

Request to an External Organization for Protected Health Information

Patient Name: _____ Birthdate: _____
Last First Middle Initial MM/DD/YYYY

Address: _____ Apt/Suite #: _____ City: _____ State: _____ Zip: _____

Phone Number: _____ MRN: _____

I give you permission to:

Name of individual or agency: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone Number: _____ Fax Number: _____

To release my health information to the following:

☐ **Bronson Battle Creek**
300 North Avenue
Battle Creek, MI 49017
Phone: (269) 245-5851, option 2
Fax: (269) 341-6528

☐ **Bronson Behavior Health**
165 N. Washington Avenue
Battle Creek, MI 49037
Phone: (269) 245-5851, option 2
Fax: (269) 341-6528

☐ **Bronson Methodist**
601 John Street, Box F
Kalamazoo, MI 49007
Phone: (269) 341-6487
Fax: (269) 341-6528

☐ **Bronson LakeView Hospital**
408 Hazen Street
Paw Paw, MI 49079
Phone: (269) 657-1465
Fax: (269) 341-6528

☐ **Bronson South Haven**
970 S. Bailey Avenue, Suite 3
South Haven, MI 49090
Phone: (269) 637-5271, option 6
Fax: (269) 341-6528

☐ **Bronson Breast Health Center**
601 John Street, Suite M-515
Kalamazoo, MI 49007
Phone: (269) 341-8432
Fax: (269) 341-7914

☐ **Bronson Physician Offices**
Office: _____
Address: _____
Physician: _____
Phone: _____ Fax: _____

☐ **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
- ☐ Immunizations
- ☐ 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
- ☐ Neurodiagnostic 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.

Patient Signature: _____ Date: _____ Time: _____

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

☐ Legal Next of Kin _____ Relationship to Patient: _____

Interpreter's Statement: I have interpreted the text on this form to the patient, a parent, closest relative or legal guardian.

Interpreter's Signature: _____ ID #: _____ Date: _____ Time: _____