

AUTHORIZATION FOR RELEASE OF PATIENT MEDICAL INFORMATION

I, _____, hereby authorize (indicate one):
PATIENT'S NAME

William Beaumont Hospital - Royal Oak
3601 W. 13 Mile
Royal Oak, Michigan 48073-6769

OTHER:

PERSON OR ORGANIZATION RELEASING INFORMATION

ADDRESS

William Beaumont Hospital - Troy
44201 Dequindre
Troy, Michigan 48098

its Director or designee, or Medical Record 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, if any, and 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:

Birthdate of Patient _____ Patient Number _____

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

William Beaumont Hospital - Royal Oak
3601 W. 13 Mile
Royal Oak, Michigan 48073-6769

OTHER:

PERSON OR ORGANIZATION

ADDRESS

William Beaumont Hospital - Troy
44201 Dequindre
Troy, Michigan 48098

2. Specific type of information to be disclosed:

Discharge Summary

Copy of Current Admission

Other (specify) _____

3. The purpose and need for such disclosure:

Continuation of Treatment or Health Care

Follow-Up

Social Service Referral

Vocational Rehabilitation

Insurance Investigation

Disability Determination

Billing Information

Other (specify) _____

4. 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. If not previously revoked, this authorization will terminate six (6) months from date of signature.

Signature of Patient/

Authorized Representative _____

Date _____

Signature of Parent/Guardian _____

Date _____

Signature of Witness _____

Date _____