AUTHORIZATION FOR
RELEASE OF PATIENT MEDICAL INFORMATION

I, _____, hereby authorize (indicate one):

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

Other: _____
PERSON OR ORGANIZATION RELEASING INFORMATION

_____

_____

William Beaumont Hospital-Troy
44201 Dequindre
Troy, MI 48098

_____

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 Code 42 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:

Patient Birth date: _____ Patient Number; _____

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

William Beaumont Hospital-Royal
3601 W 13 Mile Rd
Royal Oak, MI 48073-6769

PROVIDERS NAME: _____
PREFERRED MEDICAL GROUP
1200 WEST 12 MILE ROAD
MADISON HEIGHTS, MI 48047
PHONE # 248-543-0600 FAX # 248-543-4720

William Beaumont Hospital-Troy
44201 Dequindre
Troy, MI 48098

Specific type of information to be disclosed:

All records

Discharge Summary

Copy of Current Admission

Other: (specify)_____

The purpose and need for such disclosure:

Continuation of Treatment or Health Care
Vocational Rehabilitation
Billing Information
Disability Determination

Follow-up
Insurance Investigation
Social Service Referral

Other: _____

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_____ Date _____

Signature of Guardian _____ Date _____
Or Parent
Signature of Witness _____ Date _____