901 Lakeshore Dr., Ishpeming, MI 49849
Hospital Fax: 906-485-2701
Bell Express Care Fax: 833-654-0645
Bell Family Medicine Fax: 833-654-0642
Bell Women's Care Fax: 833-654-0646

* R O I *

*Medical Record#* _____

## MEDICAL/TREATMENT INFORMATION RELEASE AUTHORIZATION

_____ Patient's Name

_____ Maiden/Previous Name, if applicable

_____ Address

_____ Birthdate

_____ City, State, and Zip Code

_____ Telephone Number

I, _____, authorize ❑ UPHS Bell Hospital ❑ Bell Physician Practices
*Name of Patient or Legal Representative* *Check appropriate box above (or both if requested)*

❑ to release information concerning the patient identified above, in accordance with state and federal laws, to the below:

_____
**Name of Person/Organization to Receive Information**

_____
**Address** **City, State, Zip Code** **Phone Number** **Fax Number**

❑ to obtain information concerning the patient identified above, in accordance with state and federal laws, from the below at 901 Lakeshore Drive, Ishpeming, MI 49849:

❑ UPHS Bell Hospital (906) 485-2701
❑ Bell Express Care (833) 654-0645
❑ Bell Family Medicine (833) 654-0642
❑ Bell Women's Care (833) 654-0646

1. **Specific information to be disclosed *(check all that apply):***
   - ❑ Discharge Summary
   - ❑ Pathology Reports
   - ❑ Progress Notes
   - ❑ Substance Abuse
   - ❑ Consultation Reports
   - ❑ History and Physical Exam
   - ❑ Radiology Films
   - ❑ Radiology Reports
   - ❑ Operative Reports
   - ❑ Emergency Room Record
   - ❑ Lab Reports
   - ❑ EKG/ Stress Test
   - ❑ Office Visit Notes
   - ❑ Copy of Complete Record
   - ❑ Discharge Instructions
   - ❑ Other, Specify: _____

**For the following date(s) or treatment of medical conditions:** _____

2. With the exception of psychotherapy notes, I authorize all information that may be contained in my medical records pertaining to psychiatric/mental health, chemical dependency, and/or AIDS/HIV related illness/testing to be released **unless** otherwise specified here: _____
   _____


3. **I am requesting this information be released for the following purposes:**
   ❑ Continued Care ❑ Insurance Claim ❑ Personal Use ❑ Attorney Review
   ❑ Other: _____

4. I understand I may revoke this authorization by written request at any time. I understand that the revocation will not apply to information that has already been released in response to this authorization.

5. I understand there may be a fee to process this release of information.

6. This authorization will automatically expire one year from the date of my signature.

7. UP Health System – Bell will not condition my continued treatment upon my signing this authorization, except for research-related treatment.

8. I understand that once my health information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure or release by the receiving Party and may no longer be protected by Federal or State law, unless protected by Federal Regulation 42 CFR Part 2 and Public Act 258 in which case it cannot be re-disclosed by the receiving Party without my written authorization.

9. I hereby agree to indemnify and hold UP Health System – Bell, their employees, and agents free and harmless from any actions against them for alleged invasion of privacy, libel or slander, or defamation arising from or related to disclosure of such information.

_____ _____
Patient/Legal Representative Signature Date

_____ _____
*Relationship, if other than Patient Witness

REASON PATIENT IS UNABLE TO SIGN: ❑ Minor ❑ Deceased ❑ Other: _____
***❑ Authority Attached** *(In non-emergency situations documentation of authority must be attached if anyone other than the patient signs this authorization.*