UP HEALTH SYSTEM
BELL

* R O I *

Medical Record# ____________________

901 Lakeshore Dr., Ishpeming, MI 49849
Hospital Fax: 906-485-2701
Clinic Fax: 906-485-2753

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 ❑ obtain 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**

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

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

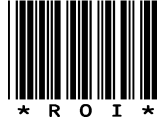
2. With the exception of psychotherapy notes, I authorize all information which may be contained in my medical records pertaining to psychiatric/mental health, chemical dependency, and/or AIDS/HIV related illness/testing to be released **unless** otherwise specified here: ______________________________________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

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.*