

ROI

Medical Record# _____

UP Health System – Bell

901 Lakeshore Dr. | Ishpeming, MI 49849

Hospital Fax | 906-485-2701

Bell Family Medicine Fax | 833-654-0642

Bell Express Care Fax | 833-654-0645

Bell Women’s Care Fax | 833-654-0646

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 the 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, to be sent to the below clinic at 901 Lakeshore Dr, Ishpeming MI 49849

| | | | |
|---|--|---|--|
| <input type="checkbox"/> UPHS Bell Hospital (906) 485-2701 | <input type="checkbox"/> Bell Express Care (833) 654-0645 | <input type="checkbox"/> Bell Family Medicine (833) 654-0642 | <input type="checkbox"/> Bell Women’s Care (833) 654-0646 |
|---|--|---|--|

1. Specific information to be disclosed (check all that apply):

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Pathology Reports | <input type="checkbox"/> Progress Notes | <input type="checkbox"/> Substance Abuse |
| <input type="checkbox"/> Consultation Reports | <input type="checkbox"/> History and Physical Exam | <input type="checkbox"/> Radiology Films | <input type="checkbox"/> Radiology Reports |
| <input type="checkbox"/> Operative Reports | <input type="checkbox"/> Emergency Room Record | <input type="checkbox"/> Lab Reports | <input type="checkbox"/> EKG/ Stress Test |
| <input type="checkbox"/> Office Visit Notes | <input type="checkbox"/> Copy of Complete Record | <input type="checkbox"/> Discharge Instructions | |
| <input type="checkbox"/> 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.)