UP HEALTH SYSTEM
BELL

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

ROI

MEDICAL/TREATMENT INFORMATION RELEASE AUTHORIZATION

Patient's Name	Maiden Name, if applicable
Address	Birthdate
City, State, and Zip Code	Medical Record Number
Telephone Number	Attending Physician

I, _____, authorize _____, its director or agent to ❑ release ❑ obtain information contained in the medical records and/or mental health, alcohol and/or drug abuse records of the patient identified above.

For mental health, alcohol and/or drug abuse patient records, I understand that my records are protected under the federal regulations governing confidentiality, including Alcohol and Drug Abuse Patient Records, 2 CFR Part 2, and cannot be disclosed without my written consent, unless otherwise provided for in the regulations. I understand that this signed authorization form may also be used by other Bell Service programs providing continuing services to me. I understand that this communication will reveal my presence as a patient at this treatment facility.

ATTENTION: PATIENT or PATIENT'S LEGAL REPRESENTATIVE: List below any information NOT to be released.

_____

1. The information may be released to the following: (name and address to whom the information is to be disclosed)

   _____

2. Specific information to be disclosed (Check all that apply):

❑ Discharge Summary	❑ History and Physical Exam	❑ Consultation Report(s)
❑ Operative Report(s)	❑ Emergency Room Report	❑ Radiology Report(s)
❑ Radiology Film(s)	❑ Laboratory/Pathology Report(s)	❑ Physical Therapy Report(s)
❑ Electrocardiogram	❑ Echocardiogram/Myoview Stress Test	❑ Occupational Therapy Report(s)
❑ Pulmonary Function Test	❑ Physician Office Note(s)	❑ Electroencephalogram
❑ Copy of Complete Record	❑ Occupational Medicine Report(s)	❑ Behavioral Services Report(s)

❑ Other, Specify: _____

_____

3. Date(s) of Service: _____

4. 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. _____ **(Initials of patient or patient's legal representative)**

5. I understand that, unless otherwise indicated or specified in this authorization, a request for disclosure or release of "all" or "any" medical records or health information may include information regarding drug and/or alcohol treatment, social service records, communications made to a social worker and HIV/AIDS and AIDS-related complex information or documentation.

6. I hereby agree to indemnify and hold Bell Hospital, Bell Medical, or its 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. I have read this consent entitled "Medical/Treatment Information Release Authorization," and I hereby acknowledge that I am familiar with and fully understand the terms and conditions of this consent.

7. I understand that my continued or future treatment by Bell Hospital or Bell Medical is not conditional upon my providing or signing this authorization, unless this authorization is provided for the purpose of providing data in connection with medical or clinical research.

8. I have been offered a copy of this authorization for my records. _____ **(Initials)**

9. I understand that I may revoke this authorization at any time by sending a ***written revocation***, to Bell Hospital or Bell Medical, except to the extent in which actions have been taken in reliance on the authorization. I also understand that this authorization will continue unrevoked until the purpose for which it was given shall have been accomplished. _____ **(Initials)**

   However, any consent given under Subpart C Federal Register, Volume 40-Number 127 July 1, 1975, shall have a duration no longer that is reasonably necessary to effectuate the purpose for which it was given.

10. **This consent expires in six (6) months.** (If the figure "six months" is crossed out, and a lesser figure is substituted, the lesser figure applies.)

_____	_____
Patient's Signature	Witness's Signature
_____	_____
**Relationship, if other than Patient	Date

****Note: If signed by a legal representative, indicate his/her relationship to the patient (parent, guardian, conservator, etc.), and attach legal documentation.**

THIS FORM MUST BE FILED IN THE PATIENT'S MEDICAL RECORD

Copies Released by: _____ Date: _____

Employee's Signature