



AUTHORIZATION FOR THE USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Check 1 site per form. Complete entire form and sign/date.

- ☐ Beacon Medical Group*/Beacon Health, LLC/Med Point ☐ Community Hospital of Bremen ☐ Elkhart General Hospital
☐ Memorial Hospital/Epworth ☐ Beacon Granger Hospital ☐ Beacon Children's Hospital

*Beacon Medical Group site-name/address/Doctor's Name:

Address: _____

City: _____ State: _____ ZIP: _____

Doctor's Name: _____

Patient Information

Name of Patient: _____ Patient's Date of Birth: ____/____/____

Address: _____

City: _____ State: _____ ZIP: _____

Ph#: _____ Previous Name(s): _____

☒ **Release** and disclose my Protected Health Information to: ☐ **Receive** my Protected Health Information from:

Name: Legal-Ease Digital Imaging Ph#: 855-543-4003 Fx#: 810-547-4030

Address: 2496 Meadowcroft Dr

City: Burton State: Michigan ZIP: 48519

Dates to be released: ____/____/____ to ____/____/____

☐ **Clinic Records** — Beacon Medical Group site — a general abstract will be sent (2 year summary unless otherwise specified)

(General Abstract includes: Office Clinic Notes, Consults, Labs, Test Results)

☐ **Hospital Summary** — a general abstract will be sent

(General Abstract includes: Discharge Summary, History & Physical, Consults, Operative Reports, Labs, Radiology Reports, and ER records)

☐ Medication Lists ☐ Billing Records ☐ Face Sheet ☐ Labs ☐ Radiology ☐ Discharge Summary

☐ ER - Emergency Room Records ☐ Operative/Procedure Reports ☐ Immunization Records ☐ Consult

☐ Copies of Films/Images (list details of type, where taken, etc.): _____

☐ Other (list details): _____

**** By selecting one or more of the ** boxes below, I specifically authorize these records to be released or shared:**

****** ☐ Behavioral health/Mental illness records

****** ☐ Treatment of Communicable Disease, including HIV/AIDS, hepatitis and venereal diseases, etc.

****** ☐ Substance abuse treatment (i.e., alcohol and/or drug) ***** ☐ Genetic Testing/Screening

Delivery Method

☐ Mail ☒ CD/DVD (not available w/all records) ☒ Electronic Delivery pat.legalease@gmail.com

List valid email address for Electronic Delivery (please print)

Purpose of Release

☒ Attorney/Legal ☐ Insurance ☐ Other: _____

There may be charges associated with processing a request and producing requested records. These charges do not apply for copies requested for continuing medical care. This authorization will expire **60** days from the date it is signed by me. I understand that the health information described above may be disclosed by the recipient and the information may no longer be protected by federal privacy regulations. I understand that Beacon Health System may receive compensation for the use and disclosure of the information. I understand that I may refuse to sign this Authorization and that my refusal to sign will not affect my ability to obtain treatment. I understand that **I may revoke this Authorization at any time by submitting my request in writing to the Privacy Officer at 615 North Michigan Street, South Bend, IN. 46601.** By signing this Authorization, I acknowledge that I have read this Authorization. Further, I authorize the use and disclosure of my Protected Health Information in accordance with the terms of this Authorization.

Signature of Patient or Personal Representative:

Date/Time:

Printed name of Patient or Personal Representative:

Relationship to Patient (Personal Representative - provide documentation)