



Affix Patient Label

Patient Name:

Date of Birth:

Request to an External Organization for Protected Health Information

Patient Name: _____ Birthdate: _____
Last First Middle Initial MM/DD/YYYY

Address: _____ Apt/Suite #: _____ City: _____ State: _____ Zip: _____

Phone Number: _____ MRN: _____

I give permission to:

Name of individual or agency: Legal-Ease Digital Imaging LLC

Address: 2496 Meadowcroft Dr City: Burton State: MI Zip: 48519

Phone Number: 855-543-4003 Fax Number: 810-547-4030

To release my health information to the following:

- | | | | |
|--|---|---|--|
| ☐ Bronson Battle Creek
300 North Avenue
Battle Creek, MI 49017
Phone: 269-245-5851
Fax: 269-341-6528 | ☐ Bronson Behavioral Health
165 N. Washington Avenue
Battle Creek, MI 49037
Phone: 269-245-5851
Fax: 269-341-6528 | ☐ Bronson Methodist Hospital
601 John Street Box F
Kalamazoo, MI 49007
Phone: 269-341-6487
Fax: 269-341-6528 | ☐ Bronson LakeView Hospital
408 Hazen Street
Paw Paw, MI 49079
Phone: 269-657-1465
Fax: 269-341-6528 |
| ☐ Bronson South Haven
955 S. Bailey Avenue
South Haven, MI 49090
Phone: 269-637-5271 ext. 2293
Fax: 269-341-6528 | ☐ Bronson Center for Women
601 John Street Suite M-515
Kalamazoo, MI 49007
Phone: 341-8432
Fax: 269-341-7914 | ☐ Bronson Physician Offices
Office: Central Services Medical Records
Address: 6901 Portage Rd. Suite 210 Portage, MI 49002
Physician: Bronson Primary Care Partners
Phone: (269) 655-3036 Fax: (269) 657-8332 | |

☐ **Fax Medical Records to Unit:** _____ Fax Number: _____ Unit Phone Number: _____

Information to be released:

Dates of Service: _____

- ☐ Admission Evaluation
- ☐ Cardiac Records
- ☐ Consults
- ☐ Discharge Summary
- ☐ History & Physical
- ☐ Lab Reports
- ☐ Mammography – *Please send available reports and images of breast related exams (including breast MRI and U/S exams) electronically. If unable to send images electronically, please mail DICOM-CD and fax corresponding report(s).*
- ☐ Medication Records
- ☐ Neurodiagnostics Records
- ☐ Operative Record
- ☐ Pathology Report
- ☐ Psychiatric Admission History
- ☐ X-Ray Reports
- ☐ Other (specify content and dates) _____

Purpose of disclosure

- ☐ Continuing Care
- ☐ Other (specify) _____
- ☐ _____



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I authorize the release of health information, contained in my medical records including:

- Information regarding communicable diseases and infections, as defined by statute and Michigan Department Of Health rules, which include venereal disease, Tuberculosis, Hepatitis A, B, C, Human Immunodeficiency Virus (HIV), HIV testing.
- Acquired Immunodeficiency Syndrome (AIDS) and AIDS related complex (ARC).
- Alcohol and drug abuse treatment information protected under the regulations in CFR 42, Part 2.
- Mental health treatment records, psychological services and social services information including communications made by me to a social worker, therapist, or psychologist.

Acknowledgement of Understanding:

- I understand this authorization will expire in one year from date signed.
- I can cancel this authorization at any time by writing to Bronson Healthcare Group (BHG).
- It will take effect on the date notified, except if action has already been taken.
- I understand that if I release my medical record to a person or provider, they can release my medical record. I know I need to check with them about their privacy rules.
- I will get an abstract of my medical record unless I ask for the complete record.
- No conditions will be placed on me if I sign this form.

Patient Signature: _____ Date: _____ Time: _____

Relationship: ☐ Patient ☐ Guardian ☐ DPOA (Durable Power of Attorney for Healthcare)
☐ Legal Next of Kin _____ Relationship to Patient: _____

Interpreter's Statement: I have interpreted the doctor's explanation of the consent form to the patient, a parent, closest relative or legal guardian.

Interpreter's Signature: _____ ID #: _____ Date: _____ Time: _____