Reset

BIMGA
BEAUMONT INTERNAL MEDICINE & GERIATRIC ASSOCIATES

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Social Security #: _____ Patient's Phone #: _____

Patient's Address:_____ City:_____ State:_____ Zip:_____

I request and authorize: (circle one)

The release of my Information **TO** the following The release of my information **FROM** the following

Name of healthcare provider(s) or facility to release information from/to:

_____

Address:_____ City:_____

State:_____ Zip:_____ Phone:_____ Fax:_____

The following information is to be disclosed:

Yes	No	
☐	☐	physician notes
☐	☐	lab results
☐	☐	cardiac studies
☐	☐	pulmonary studies
☐	☐	x-ray/diagnostic imaging reports
☐	☐	complete record
☐	☐	other:_____

I understand that my medical record may contain reports, test results & notes that only a physician can interpret. I understand I should not contact my physician regarding the entries made in my medical record to prevent my misunderstanding the information.

I will not hold Beaumont Internal Medicine & Geriatric Associates liable for any misinterpretation of the information in my medical record as a result of not consulting my physician for his/her interpretation.

I understand the information in my record may include information relating to sexually transmitted diseases, acquired immunodeficiency (HIV). It may also include information about behavioral or mental health services or treatment for alcohol & drug abuse.

Right to revoke: I understand I have the right to revoke this authorization at any time. I understand my revocation must be in writing. I understand the revocation will not apply to information already released.

Other Rights: I understand I may inspect or obtain a copy of the information to bemused or disclosed.

Expiration: Unless otherwise revoked, this authorization will expire on the following date, event, or condition. (if an expiration date, event, or condition is not specified, this authorization will expire in 6 months.) DATE OF EXPIRATION:_____

Signature of Patient or Legal Representative:_____

If signed by representative, what is relationship?_____

Date:_____

E-MAIL TO: MedicalRecords@BIMGA.COM