BIMGA
BEAUMONT INTERNAL MEDICINE & GERIATRIC ASSOCIATES

AUTHORIZATION TO RELEASE

HEALTHCARE INFORMATION

PHONE
(409) 898-2994
FAX
(409) 899-5542
EMAIL
Medicalrecords@bimga.com

PATIENT INFORMATION

PATIENT'S FULL NAME

DATE OF BIRTH

SOCIAL SECURITY #

PATIENT'S PHONE #

STREET ADDRESS

CITY

STATE

ZIP

AUTHORIZATION DIRECTION — CIRCLE ONE

○ **Release My Information TO the following**
Send my records to the provider listed below

○ **Release My Information FROM the following**
Receive records from the provider listed below

HEALTHCARE PROVIDER OR FACILITY

NAME OF PROVIDER / FACILITY

STREET ADDRESS

CITY

STATE

PHONE

FAX

INFORMATION TO BE DISCLOSED

Physician Notes	☐ YES	☐ NO	X-Ray / Diagnostic Imaging Reports	☐ YES	☐ NO
Lab Results	☐ YES	☐ NO	Complete Record	☐ YES	☐ NO
Cardiac Studies	☐ YES	☐ NO	Pulmonary Studies	☐ YES	☐ NO
Other: _____				☐ YES	☐ NO

I understand my medical record may contain reports, test results, and notes that only a physician can interpret. I should not contact my physician solely regarding entries in my record to prevent misunderstanding. I will not hold **Beaumont Internal Medicine & Geriatric Associates** liable for any misinterpretation resulting from not consulting my physician.

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

Right to Revoke: I have the right to revoke this authorization at any time in writing. Revocation will not apply to information already released. **Other Rights:** I may inspect or obtain a copy of the information to be used or disclosed.

⏳ **Expiration:** By initialing here _____ I certify this authorization will remain **valid indefinitely** unless revoked in writing. If I choose *not* to initial, this authorization will **expire in six (6) months** from the date signed below.

SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE

RELATIONSHIP (IF REPRESENTATIVE)

DATE SIGNED