BEACON HEALTH SYSTEM

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: _____ Ph#: _____ Fx#: _____

Address: _____

City: _____ State: _____ ZIP: _____

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 _____
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)**