



BEALS INSTITUTE, P.C.

ARTHRITIS, OSTEOPOROSIS AND AUTOIMMUNE DISEASES

4333 W. St. Joe Hwy, Lansing, MI 48917 • (517) 321-1525 • Fax: (517) 321-7059

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____

Address: _____ Phone: _____

INFORMATION REQUESTED:

<input type="checkbox"/> History & Physical	<input type="checkbox"/> Discharge summary	<input type="checkbox"/> Emergency/UC reports
<input type="checkbox"/> Operative reports	<input type="checkbox"/> Lab/Pathology reports	<input type="checkbox"/> X-ray reports
<input type="checkbox"/> Progress Notes	<input type="checkbox"/> Immunizations	<input type="checkbox"/> Consults/Letters
<input type="checkbox"/> All	<input type="checkbox"/> Other _____	

From: _____ To: _____

There may be a charge for copying medical records depending on the number of copies and length of time to copy.

Information may include any of the following:

- Alcohol or drug abuse, or mental health treatment information protected under Title 42 or the Code of Federal Regulation Part II.
- Serious communicable and infectious diseases as defined by the Michigan Department of Public Health Code 1989, Act 174, which includes venereal disease, tuberculosis, human immunodeficiency virus (HIV), acquired immunodeficiency syndrome (AIDS), Aids Related Complex (ARC), and hepatitis
- Records or reports sent to Beals Institute, P.C. or Carol A. Beals, M.D., or Russel York, M.D., from other health care providers, including hospitals and physicians.

PURPOSE OF DISCLOSURE:

<input type="checkbox"/> Attorney/Legal	<input type="checkbox"/> Continued Patient Care	<input type="checkbox"/> Insurance	<input type="checkbox"/> Personal Use
<input type="checkbox"/> Worker's Compensation	<input type="checkbox"/> Disability	<input type="checkbox"/> Other _____	

This consent may be revoked at any time by writing to the address below, except for any action that has already been taken in reliance upon it.

Expiration date: _____ **or action:** _____

If no express revocation is issued, this authorization will expire 180 days (6 months) from the date signed.

I understand that Health Information that is released under this Authorization may be subject to re-disclosure by the recipient and the privacy of my Health Information may no longer be protected by the law.

Signature of Patient or Legal Representative

Date

Relationship to Patient