RECORDS DEPOSITION SERVICE
PO BOX 5054 • SOUTHFIELD, MI 48086-5054
P: 248.357.3330 • F: 248.357.3337 • INFO@RECDEP.COM

MEDICAL AUTHORIZATION

I, _____ _____ _____
(Patient Name) **(Date of Birth)** **(Social Security Number)**

hereby authorize

_____
(Hospital/Health Care Provider/Doctor Name)

its Director or Designee, or Medical Record Department, to release information contained in my patient records, including alcohol and drug abuse records protected under the regulations in Code 42 of Federal Regulations, Part 2, if any; Psychological Services Records, if any; Social Services Records, if any; Psychiatric Records, if any, including communications made by me to a Social Worker, Psychologist or Psychiatrist, if any; Human Immunodeficiency Virus (HIV), Acquired Immunodeficiency Syndrome (AIDS), and AIDS Related Complex (ARC) Records, if any; Communicable Disease and Serious Communicable Disease and Infections, Venereal Diseases, Tuberculosis, Hepatitis B, Sickle Cell Anemia Records, if any, to:

RECORDS DEPOSITION SERVICE, INC., PO Box 5054, Southfield, MI 48086-5054

Note: Disclosure is to be made to Records Deposition Service, Inc. only. All other disclosures are unauthorized!

1. Information to be disclosed: **Please see enclosed Subpoena or Letter Request for information to be disclosed.**
2. The purpose and need for such disclosure: **For Discovery Before Trial**
3. This Authorization is subject to revocation at any time by contacting Records Deposition Service, Inc. in writing. I understand that the revocation will not apply to information that has already been released in response to this Authorization.
4. Without expressed revocation, this authorization expires on the date set forth: _____ or the following event: Once information is disclosed, no further information can be disclosed pursuant to this authorization.
5. I understand the provider may not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this form.
6. A photocopy of this document shall be considered valid as if the original were offered. This Authorization is only valid if submitted by Records Deposition Service, Inc. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by Federal or State Law. Records Deposition Service, Inc. is not liable for damages as the result of an unauthorized disclosure.

_____ _____ _____
Signature of Patient **Printed Name** **Date Signed**

_____ _____ _____
Signature of Parent/Guardian/Personal Representative **Printed Name** **Date Signed**

_____
Relationship to Patient