Fresenius Medical Care

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

PLEASE CHECK THE APPROPRIATE BOX(ES)

Patient or Legal Representative request for:

- ☐ Physical (On-Site) Access to view medical records (PHI), and/or
- ☑ Authorization for the release of medical records (PHI) to third party, and/or
- ☐ Authorization for the release of medical records (PHI) to self.

I. PATIENT INFORMATION
a. Name:
b. Request date:
c. Location where the patient receives treatment:
d. Patient Medical Record Number (MRN):

II. INFORMATION TO BE USED OR DISCLOSED

I hereby authorize Fresenius Medical Care North America ("FMCNA"), and its employees and agents, to use or disclose my protected health information ("information") as specified below.

I understand that this Authorization is valid only for the use(s) and disclosure(s) specifically described in this document.

a. Information to be used or disclosed, check all that apply:

Patient demographic and other general information:

Check		**Type of information**
Y	**N**	
		Name
		Address
		Date of birth or age
		Social Security number
		Medical record number or other identifier
		Financial information

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Medical Record Information:

Check Y	Check N	Record	Date(s) of Service(s)
		Medical Treatment Record (specify the information being requested, i.e. Treatment Flow Sheets, Progress Notes, Laboratory Results, care Plans, etc.)	
		Confidential information and records regarding AIDS or HIV infection	
		Mental health care	
		The entire medical Treatment Record	

b. The information will be used by or disclosed to the following person(s), entity or class of persons or entities: RECORDS DEPOSITION SERVICE, INC.

c. The address of the person or entity receiving the information is: (No P.O. Boxes)

☐ Check here if address not known

27355 WEST ELEVEN MILE ROAD
SOUTHFIELD, MI 48033
P: 248-357-3330 F: 248-357-3337

d. The information will be used for the following purpose(s):

FOR DISCOVERY BEFORE TRIAL

☐ Check here if the disclosure is at the request of the patient and no further purpose is provided.

e. This Authorization will expire:

Provide an expiration date or event. This must be a specific date, a specific time period (i.e., "One year from the date of signature"), or an event directly relevant to the individual or the purpose of the use or disclosure (i.e., "When the patient is no longer treated at the facility.").
If no date or event provided, authorization will expire one (1) year from the date of signature.

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III. PATIENT AUTHORIZATION

(To be completed by the patient or the patient's legal representative.)

I have reviewed the information completed above and understand it. I understand that if I have questions about this form or the information that is completed above that I may ask the manager of the FMCNA location where I receive treatment to answer my questions, I may call 1-800-662-1237 Ext. 9099 and ask that an FMCNA representative contact me, or I may e-mail Privacy@fmc-na.com. **I understand that I should never sign this form if it is blank or if the sections above are not filled out.**

I understand that I may revoke this authorization by submitting a written revocation to:
Privacy Officer
Fresenius Medical Care North America
920 Winter Street
Waltham, Massachusetts 02451-1457

Any revocation shall not be effective with respect to any use or disclosure made by FMCNA in reliance on this authorization prior to the date of FMCNA's receipt of my revocation.

I understand that FMCNA cannot require me to sign this authorization in order to receive treatment unless the provision of health care by FMCNA is only for the purpose of creating information for disclosure to a third party (for example, an employee physical exam) or for research-related treatment, in which case FMCNA will not provide the service unless I sign this authorization.
I understand that the information used or disclosed by FMCNA pursuant to this authorization may be subject to redisclosure by the recipient in which case it might no longer be protected under the HIPAA Privacy Rule.
I understand that in some cases, the person or entity receiving the information covered by this Authorization may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements. I authorize FMCNA to copy this Authorization and to send the recipient the redisclosure notice required under the Federal Substance Abuse Confidentiality Requirements, if my records contain information protected by those laws.

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a. Patient Name and Name of patient's legal representative (if applicable) (Please Print)
b. Signature of patient or the patient's legal representative:
c. Date of signature:

The following should be filled out by patient requesting copy of PHI.
I wish to have a copy of my information:

☑ Shipped (via a trackable method) to the address listed above in II.c., or

☐ Available for me to pick up at the location where I receive treatment.

- I understand that FMCNA may charge a copying fee, as allowed by state law, if I request a copy of my information.
- I will have to pay shipping charges if I request FMCNA to ship the copy to me.
- FMCNA will inform me of the fees that will apply to my request, if any. I understand that I am responsible for paying such fees.
- Copying and shipping services are not covered by insurance.
- I may withdraw or change my request if I do not want to pay these fees.
- If there are fees, I must pay them in full before FMCNA makes the copies or ships them to me.

a. Patient Name and Name of patient's legal representative (if applicable) (Please Print)
b. Signature of patient or the patient's legal representative:
c. Date of signature:

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To be completed by FMCNA staff:

FMCNA will charge the following fee for the service requested above:

☐ There will be no fee for the requested service.

☐ The following fees apply to the requested service:

Copying Fee	$
Shipping Fee	$

Name of FMCNA Staff Member (Please Print)	
Signature of FMCNA Staff Member	
Date	

To be completed by the patient if fees apply:

I agree to pay the fees indicated above.

a. Patient Name and Name of patient's legal representative (if applicable) (Please Print)
b. Signature of patient or the patient's legal representative:
c. Date of signature: