LEGACY HEALTH

AUTHORIZATION TO USE AND/OR DISCLOSE PROTECTED HEALTH INFORMATION

The information used or disclosed pursuant to this authorization may be subject to redisclosure and may no longer be protected under federal law.
Refusal to sign this authorization will not affect the patient's ability to obtain health care services or reimbursement for services unless authorization is required to bill the patient's insurance company.

Patient Last Name	Patient First Name	Middle Name
Nickname/Maiden Name	Birth Date	Telephone: Okay to leave detailed message? ☐ Yes ☐ No
Patient's Mailing Address		

Healthcare Provider to **Release** Information:

Name		
Address		
City	State	Zip
Phone	Fax	

Person or Agency to **Receive** Information:

Name **RECORDS DEPOSITION SERVICE, INC.**		
Address **PO BOX 5054**		
City **SOUTHFIELD**	State **MI**	Zip **48086-5054**
Phone **248-357-3330**	Fax **248-357-3337**	

Purpose of release: **FOR DISCOVERY BEFORE TRIAL**

If such information exists, I authorize the disclosure of ☐ the entire medical record or ☒ the following specific documents, dates of service, and/or information about the following injury/illness/disease:

Please see enclosed Subpoena or Letter Request for information to be disclosed.

The following items **must be initialed** to be released:

_____ HIV-positive test results and HIV diagnosis

_____ Mental health information and/or records (Oregon only)

_____ Genetic testing information and/or records (Oregon only)

_____ Other sexually transmitted diseases (Washington only)

_____ Drug/alcohol diagnosis, treatment or referral information. Per Federal regulations, describe how much and what kind of information is to be disclosed: _____

Federal or state law may restrict redisclosure of HIV-positive test results and HIV diagnosis, other sexually transmitted disease information, specially protected mental health information, genetic testing information, and drug/alcohol diagnosis treatment or referral information.

The person or entity I am authorizing to use and/or disclose the information may receive compensation for doing so.

The only circumstance when refusal to sign means the patient will not receive health care services is if the health care services are solely for the purpose of providing health information to someone else, and the authorization is necessary to make that disclosure. My refusal to sign this authorization will not adversely affect my enrollment in a health plan or eligibility for health benefits unless the authorized information is necessary to determine if I am eligible to enroll in the health plan.

I may revoke this authorization in writing at any time, except to the extent that action has been taken in reliance upon this authorization. If I revoke my authorization, the information described above may no longer be used or disclosed for the purpose described in this authorization. Unless revoked earlier, this authorization will expire on the earlier of 1 year from the date of signing or on _____.

_____ _____

Signature of Patient or Patient's Legal Representative | Date

_____ _____

Print Name (If other than patient, proof of authority is required.) | Relationship to Patient