Authorization for Use and Disclosure of Protected Health Information

Patient Identification

Printed Name: _____ Date of Birth: _____

Address: _____

_____

Social Security #:_____ Telephone: _____

Information To Be Released – Covering the Periods of Health Care

From (date) _____ to (date) _____

From (date) _____ to (date) _____

Please check type of information to be released:

☐ Complete health record	☐ Diagnosis & treatment codes	☐ Discharge summary
☐ History and physical exam	☐ Consultation reports	☐ Progress notes
☐ Laboratory test results	☐ X-ray reports	☐ X-ray films / images
☐ Photographs, videotapes	☐ Complete billing record	☐ Itemized bill

☒ Other, (specify) **SEE ATTACHED SUBPOENA**

Purpose of Request

☐ Treatment or consultation	☐ At the request of the patient	☐ Billing or claims payment

☒ Other, (specify) **FOR DISCOVERY BEFORE TRIAL**

Who and Where to Send / Release Information

Name: **RECORDS DEPOSITION SERVICE, INC.**

Address: **PO BOX 5054, SOUTHFIELD, MI 48086-5054**

P: 248-357-3330 F: 248-357-3337

Drug and/or Alcohol Abuse, and/or Psychiatric, and/or HIV/AIDS Records Release

I understand if my medical or billing record contains information in reference to drug and/or alcohol abuse, psychiatric care, sexually transmitted disease, Hepatitis B or C testing, and/or other sensitive information, I agree to its release. ***Check One:*** **Yes** **No**

I understand if my medical or billing record contains information in reference to HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome) testing and/or treatment I agree to its release. ***Check One:*** **Yes** **No**

Time Limit & Right to Revoke Authorization

Except to the extent that action has already been taken in reliance on this authorization, at any time I can revoke this authorization by submitting a notice in writing to the facility Privacy Officer at *[location & mailing address]*. Unless revoked, this authorization will expire on the following date or event _____, or 180 days from date of signature, unless otherwise specified.

Re-disclosure

I understand the information disclosed by this authorization may be subject to re-disclosure by the recipient and no longer be protected by the Health Insurance Portability and Accountability Act of 1996. The facility, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Signature of Patient or Personal Representative Who May Request Disclosure

I understand that I do not have to sign this authorization, and my treatment or payment for services will not be denied if I do not sign this form unless specified above under Purpose of Request. I can inspect or copy the protected health information to be used or disclosed.
I authorize *[name of facility]* to use and disclose the protected health information specified above.

Signature: _____ Date: _____

Authority to Sign if not patient: _____

Identity of Requestor Verified via: **Photo ID** **Matching Signature** **Other, specify** _____

_____ Verified by: _____