PATIENT NAME	DATE OF BIRTH

NAME OF PERSON AUTHORIZED TO RECEIVE INFORMATION		PHONE #:
RECORDS DEPOSITION SERVICE, INC.		**P: 248-357-3330**
ADDRESS **PO BOX 5054**		**F: 248-357-3337**
CITY **SOUTHFIELD**	STATE **MI**	ZIP **48086-5054**
PURPOSE FOR DISCLOSURE **For Discovery Before Trial**		

DATE(S) OF CARE/SERVICE	CARE OR SERVICE INFORMATION TO BE RELEASED		
	☐ History and Physical	☐ Laboratory Report	☐ Billing Records
	☐ Discharge Summary	☐ X-Ray Report	
	☐ Consultation Report	☐ Cath/Angio Films	
	☐ Operative Report	☐ Cardiopulmonary Report	
	☐ ER Record	☐ Pathology Report	
	☐ Physical Rehab	☒ Other: **Please see enclosed Subpoena or Letter Request for information to be disclosed.**	

I hereby authorize Yavapai Regional Medical Center (YRMC) to furnish to the Authorized Person(s) named above a copy of the information related to type of care or service(s) indicated above that was provided to the Patient for the date(s) stated above.

This authorization will be considered invalid after one year
OR based on expiration date or event as noted here. EXPIRATION DATE OR EVENT: ____________________.

I may revoke this authorization at any time, with some exceptions, except to the extent YRMC has already taken action based on this authorization. I may revoke this authorization by providing written notice of revocation to YRMC's Health Information Management Department. I understand that:

(1) authorizing the disclosure of this health information is voluntary;
(2) I can refuse to sign this authorization;
(3) I need not sign this form to ensure treatment;
(4) a revocation of this authorization will not apply to information that has already been released in response to this Authorization;
(5) I authorize YRMC to use or disclose information relating to **(initial all that apply)**:
 _________ AIDS/HIV
 _________ Communicable disease other than AIDS/HIV
 _________ Behavioral health care/psychiatric care/mental health
 _________ Alcohol and/or drug abuse treatment
 _________ Genetic testing information
(6) if this information is disclosed to a third party, the information may no longer be protected by the federal privacy regulations and may be re-disclosed by the person or organization that receives the information.

I understand the matters discussed on this form. I release the provider, its employees, officers and directors, medical staff members, and business associates from any legal responsibility or liability for the disclosure of the above information to the extent indicated and authorized herein.

PATIENT (PRINT)	PATIENT SIGN	DATE

LEGALLY AUTHORIZED REPRESENTATIVE NAME (PLEASE PRINT)	LEGALLY AUTHORIZED REPRESENTATIVE SIGNATURE	DATE
DESCRIPTION OF REPRESENTATIVE'S AUTHORITY TO ACT FOR PATIENT		
IF PATIENT IS UNABLE TO CONSENT, STATE REASON		

REQUEST COMPLETED BY	DEPARTMENT	DATE REQUEST COMPLETED
	MR #	ACCT #

YAVAPAI REGIONAL MEDICAL CENTER
1003 Willow Creek Rd. - Prescott AZ 86301
7700 E. Florentine Rd. - Prescott Valley AZ 86314

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

CONSENTS & OPERATIONS
MR-1036 (11/11)