

INSTRUCTIONS: This authorization is made by you for the disclosure of your health information, as indicated. Please complete each section. Sections NOT completed may delay health information from being disclosed.

SECTION 1 - Patient Information							
Patient Full Name - First, Middle, Last:		Birthdate:					
				Month	Day	Year	
Patient Address - Street/Apt/Suite:		City	T.		State:	Zip:	
Phone Number:	Fax Number:	Soc	cial Security Number (Last 4)	OFFICE USE	ONLY: Patient	MRN/Encounter Number	
			x-xx				
SECTION 2 - Disclosure of Health Information							
I authorize to □ Disclose □ Obtain □ Disclose and Obtain							
Disclose To (facility name)							
Name of Facility/Entity/Individual: RECORDS DEPOSITION SERVICE, INC							
Street Address/Apt/Suite: PO BOX 5054		(City: SOUTHFIELD		State: MI	^{Zip:} 48086-5054	
Phone Number: 248.357.3330		•	Fax Number: 248.357.3337				
Obtain From							
Name of Facility/Entity/Individual:							
Street Address/Apt/Suite:			City:		State:	Zip:	
Phone Number: For Direct Patient Ca			For Direct Patient Care O	Only - Fax Number:			
SECTION 3 - Purpose Of Disclosure							
✓ Legal							
☐ Insurance ☐ Persor	nal Use	spec	ify)				
SECTION 4 – Requested Format							
□ Paper ☑ Electronic Media □ Verbal Disclosure (For Use in Behavioral Health Programs Only)							
SECTION 5 - Delivery Method							
□ Verbal Disclosure (For Use in Behavioral							
SECTION 6 - Dates of Treatment							
Dates of treatment to be disclosed (i.e. specific date 1/25/15; or a range of dates Jan-July 2017):							
SECTION 7 - Medical/Surgical Health Information To Be Disclosed - Check All That Apply							
Record Abstract (History and Physical, Emergency Room Record, Lab, Radiology, Operative Report, Pathology Report, Consultation Report, D/C Summary and other diagnostic tests).							
☐ Emergency Report ☐ History and Physical(s) ☐ Clinic Notes (specify clinic)							
☐ Consultation(s) ☐ Progress Note(s)	•	Rehab or Therapy Notes (specify type)					
☐ Operative/Procedure Report(s	☐ Prenatal Summar	☐ Prenatal Summary					
☐ Laboratory Results	′ ☐ Entire Chart						
☐ Pathology Results	☐ Itemized Bill	☐ Itemized Bill ☑ Other (specify) PLEASE SEE ATTACHED SUBPOENA OR REQUEST FOR INFORMATION					
☐ Radiology Report(s)						R INFORMATION	
☐ Radiology films/digital images☐ EKG/Stress Test(s)	☐ Discharge Summ	☐ Discharge Summary					
Authorization for Release of							
Patient Health Information	on						
					Place La	bel Here	

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SECTION 8 – Specific Consent MUST BE COMPLETED FOR ALL REQUESTS							
If any of the highly confidential information listed below is contained in the medical records requested, I am specifically authorizing the use and/or disclosure of this information by checking the boxes below, if applicable to this authorization. □ Information about Mental/Behavioral Care and Treatment □ Information about Sexually Transmitted Disease(s)							
☐ Information about Substance Use Disorder Care and Treatment ☐ Information about Genetic Testing							
☐ Information about Psychological Testing ☐ Information about Sexual Assault/Abuse							
☐ Information about HIV/AIDS Testing or Treatment ☐ Information about Child Abuse and Neglect							
☐ Pregnancy (the patient 12 or over must authorize this release) ☐ Not Applicable to this authorization							
SECTION 9 - Behavior Health/Substance Use Disorder Treatment Information To Be Disclosed							
Check All That Apply: ☐ Inpatient Stay: An abstract of the record will be provided, which includes Test Results, History and Physical, Psychiatric Evaluation, Consultations, Discharge Summary, Face Sheet, unless otherwise specified. ☐ History & Physical Screen ☐ Dates of Admission and Discharge ☐ Education Department ☐ Psychiatric Diagnosis ☐ Attendance/Tuition ☐ Medical Diagnosis ☐ CD Diagnosis ☐ CD Diagnosis							
☐ Psychological Testing ☐ Medication information ☐ Treatment Information ☐ Follow Up Care ☐ Homework Information ☐ IEP of 504 Plan							
□ Psychological Evaluation □ Radiology Results □ Treatment Plan □ Assessment (specify type) □ Behavioral/History of Client							
☐ Other (specify)							
SECTION 10 – Authorization Expiration Date							
This authorization is approved for: This occurrence only 60 days from the date of signature 1 year from the date of signature (mental health records only) *Only effective for this occurrence if none is chosen.							
SECTION 11 – Important Information							
I have read and understand the following statements:							
Note: If the authorization is for disclosure of mental health records, it must have a calendar date expiration or the information may only be disclosed on the date the request is received. If this authorization is for medical/surgical or research, an expiration date is not required.							
I understand that my health information may be shared with other AMITA healthcare providers for the purposes of treatment and care coordination.							
I understand that I have the right of access to inspect and obtain a copy of my health Information.							
I understand that I can cancel this authorization at any time by submitting a written notice to the physician office or Health Information Management Department of the hospital where my health information is stored. I understand that my cancellation will take effect when the Health Information Management Department receives my written notice.							
I understand that my cancellation will not have any effect on health information released before the Health Information Department received my written notice.							
I understand that health information used or disclosed may be subject to re-disclosure by the recipient and no longer protected by the privacy rule.							
I understand that under the provisions of the Illinois Mental Health and Development Disabilities Confidentiality Act or the Confidentiality of Alcohol and Substance Abuse Patient Records Act, information may not be re-disclosed unless the person who authorized this disclosure specifically authorizes the re-disclosure.							
I understand that failure to provide all required information on this authorization form will not constitute a proper authorization to disclose protected health information, including the refusal to sign this authorization and that, therefore, my request may not be honored.							
I understand that refusal to sign this authorization will not affect any conditions of my treatment, payment, enrollment, or eligibility for benefits.							
SECTION 12 – Signatures							
*Patients 12-17 years of age must sign for Behavioral Health, Substance Use, HIV/AIDS, STD, Pregnancy, Birth Control information. **Legal Representative or Guardian, please attach a court order or other documentation designating your legal status, as applicable. ***Signature of witness who can attest to the identity of the authorized signatory is required to release any mental health or developmental disability information. The witness cannot be the same person as the authorized signatory.							
*Signature of Patient Date *** Signature of Witness Date							
**Signature of Parent, Legal Representative or Legal Guardian Date Relationship of Parent, Legal Representative or Legal Guardian							
Place Label Here							