AUTHORIZATION FOR USE & DISCLOSURE OF HEALTH INFORMATION

I hereby authorize Silver Cross Hospital to receive &/or disclose information from the health records of:

Patient's Name:_____ Date of Birth: _____ Social Security Number:_____

Address:_____ City:_____ State:_____ Zip:_____

Telephone Number: (____)_____ Dates of Treatment: _____

Medical Record Number _____ Hospital Visit Number_____

The specific information to be used or disclosed is as follows:

_____complete health record (every page)
_____abstract of record: (includes the following reports)
_____discharge summary_____ history & physical _____ emergency room record _____ consultations
_____operative reports _____ pathology reports _____ laboratory reports _____ radiology reports
_____cardiology reports _____ other testing results _____ OT/PT summary _____ immunization record
_____physician orders
_____physician progress notes
_____nurses notes
_____medication record
_____Other (specify)_____

I understand that the information in my health record may include information related to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

This information may be disclosed to and used by the following individual or organization:

RECORDS DEPOSITION SERVICE
P.O. BOX 5054
SOUTHFIELD, MI 48086-5054

(248) 357-3330
F (248) 357-3337
E REQUESTS@RECDEP.COM

for the purpose of FOR DISCOVERY BEFORE TRIAL
(e.g. further care, insurance claim, attorney inquiry, at the request of the individual, personal use, etc)

I understand that I have a right to revoke this authorization, in writing to the HIM/Medical Record Department, at any time. I understand that the revocation will not apply to information that has already been released in response to this authorization.
This authorization is valid until:

_____
(If I fail to specify an expiration date, event or condition, this authorization will expire in ninety (90) days)

I understand that this authorization is voluntary. I can refuse to sign this authorization. I understand that if I refuse to sign this authorization, the hospital may not refuse to treat me or refuse to submit claims for services to my health plan. I understand that I have a right to inspect and copy the information to be used or disclosed pursuant to this authorization. I understand that once this information is received by the authorized person or organization, then it may be subject to redisclosure and may no longer be protected by federal privacy laws.

I hereby authorize the above use and disclosure:

_____ _____
Signature of Patient or Legally Authorized Representative *Date*

_____ _____ _____
Printed name of legal representative *Representative's relationship to Patient* *# of pages released*

_____ _____ _____
Signature of Witness *Date* *Released by*

04/03