4535 Dressler Rd. NW, Canton, OH 44718
1-855-687-0618 Fax (330) 492-8489

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

45 CFR §164.508

Federal and State law, including the Health Insurance Portability and Accountability Act ("HIPAA"), requires health care providers to protect your health information. US Acute Care Solutions ("USACS") provides billing and management services for affiliated or contracted healthcare providers, who provide acute medical services.

Print Patient Name: _____

I authorize USACS and/or its employees or agents, including the treating physician or other health care provider, to release and disclose my Protected Health Information ("PHI") under the restrictions and conditions in this Authorization form.

1. The following PHI may be released or disclosed:

   ☐ a. Billing records

   ☐ b. Medical records

   ☐ c. Billing and medical records

   For medical services received by me (check and complete only one):

   ☐ Date of medical treatment for illness, injury, or accident on: _____(date).

   ☐ Dates of medical treatment for illness, injury or accident

   from: _____(date) to: _____(date).

   ☐ At any and all times and dates treated.

2. The PHI specified in this Authorization may be released and/or disclosed to the following individual(s) and/or organizations (such as carriers, insurance companies, lawyers, law firms, etc.): **MUST BE FILLED OUT**
   RECORDS DEPOSITION SERVICE, INC., PO BOX 5054, SOUTHFIELD, MI, 48086-5054

3. I am authorizing disclosure of my PHI for the following purpose (check): ☐ At my request

4. I understand that this Authorization may include disclosure of information relating to alcohol and drug abuse, mental health treatment (except psychotherapy notes), genetic testing information, and confidential AIDS/HIV related information.

5. I understand that if whoever receives my Protected Health Information (PHI) is not a health care provider or health plan covered by federal privacy regulations, the disclosed information may be redisclosed and is no longer protected by those regulations. I release any and all parties permitted to disclose my PHI by this Authorization, and their employers and staff, from all liability arising from the disclosure of my PHI under this Authorization.

6. I understand that I have the right to revoke this Authorization, in writing, at any time by sending written notice to: Privacy Officer, 4535 Dressler Road NW, Canton, OH 44718. I understand that a revocation is not effective to the extent that action has already been taken in reliance upon this Authorization.
7. I understand that I may refuse to sign this Authorization and that my refusal to sign will not affect my ability to obtain treatment, payment or my eligibility for benefits.
8. Unless otherwise revoked, this authorization will expire 1 year from the date of the signature, unless an earlier date, event, or condition is noted here: _____

_____
Printed Patient's Name

Address of Patient:

_____

_____

Last 4 digits of SSN: _____

_____
Signature of Patient

_____
Date Signed

_____
Print Name of Patient's Personal Representative/Guardian

Address of Personal Representative/Guardian:

_____

_____

Description of Representative's Authority to Act for the Patient:

- ☐ Parent
- ☐ Medical Power of attorney/representative
- ☐ Legal guardian
- ☐ Health care surrogate
- ☐ Other; specify _____

_____
Signature of Personal Representative or Guardian

_____
Date Signed