AUTHORIZATION FOR USE/DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient name: ___________________________________ DOB: _______________

I authorize Advanced Radiology Services, P.C. ("ARS") to disclose my protected health information during the term of this authorization to the recipient(s) that I have identified below.

Recipient Name: RECORDS DEPOSITION SERVICE, INC. REQUESTS@RECDEP.COM

Address: PO BOX 5054, SOUTHFIELD, MI 48086-5054 Phone: 248.357.3330

Purpose: I authorize the release of my health information for the following specific purpose:
☐ At the patient's request. ☒ Other: LEGAL DISCOVERY

Information to be disclosed: I authorize the release of the following protected health information (check the applicable box below). *Note: ARS does not maintain radiology images and reports. For images and reports, patient must submit a separate request to the facility where the test was administered.*
❑ Billing and financial information.

Term: I understand that this authorization will remain in effect:
❑ From the date of this authorization until the _____ day of ________, 20___.
❑ Until the ARS fulfills this request.
❑ Until the following event occurs:____.

Redisclosure: I understand that ARS cannot guarantee that the recipient will not redisclose my health information to a third party. The third party may not be required to abide by this authorization or applicable federal and state law governing the use and disclosure of my protected health information.

Refusal to sign/right to revoke: I understand that signing this form is voluntary and that if I don't sign, it will not affect my treatment. If I change my mind, I understand that I can revoke this authorization by providing a written notice of revocation to the ARS Compliance Officer at 3264 N Evergreen Dr NE, Grand Rapids, MI 49525. The revocation will be effective immediately upon ARS's receipt of my written notice, except that the revocation will not have any effect on any action taken by ARS before it received my written notice of revocation.

Patient signature: ___________________________________ Date: _______________

If the patient is unable to sign this authorization, please complete the information below:

Name of personal representative: ____

Legal authority (e.g. parent): ____

Representative signature: _________________________________ Date: ____________