Atrio Home Health
Authorization for Release of Information
Other than for Treatment, Payment, or Operations

Name of Client:_____ Date:_____

1. **Authorization**. I hereby authorize the use and disclosure of my health information as indicated below. I understand that this release is voluntary.

2. **Party Who May Release and Information to be Disclosed**. I hereby authorize the release by Atrio Home Health of the information checked and/or listed below for the time period _____:

[ ] Complete health care record(s)
[ ] History & Physical Examination
[ ] Minimum Data Set
[ ] Laboratory Reports
[ ] Medical / Treatment Records
[ ] Pathology Reports
[ ] X-Ray Reports
[ ] Transcribed Reports
[ ] Nurses' Notes
[ ] Other:_____

[ ] Discharge Summary
[ ] Progress Notes
[ ] Care Plans
[ ] Dental Records
[ ] Photographs, Video Tapes, Digital, or other images
[ ] Billing Statements
[ ] Emergency Care Records
[ ] Consultant Reports

[ ] Other:_____

3. **Party or Parties To Whom Information May Be Released**. The information checked and/or listed above is to be released to and discussed with this or these recipient(s) (Name, Address and Phone Number):

RECORDS DEPOSITION SERVICE, INC.

PO BOX 5054, SOUTHFIELD, MI, 48086-5054

P: 248-357-3330 F:248-357-3337

4. **Purpose of Request**. I understand that I am not required to disclose the purpose of my request. If I do not wish to do so, I will check the box that says "At my request." If I wish to provide more detailed information, I may do so. The purpose of this request is:

- ☐ At my request. (Note: this is a sufficient description of the purpose when an individual initiates the authorization and does not, or elects not to, provide a statement of the purpose.)
- ☐ Description of request: _____

5. **Expiration of Request**. Unless otherwise revoked by me, I understand that this Authorization will expire on (choose one of the boxes below):

- ☐ On the following date: 12 months after the date of the signature
- ☐ Upon the following event: _____

6. **Conditioning of Treatment, Payment, Enrollment, or Eligibility on Signing.**

Atrio Home Health may not condition treatment, payment, enrollment in a health plan or eligibility for benefits on whether the Client or his or her representative signs this Authorization.

7. **Inspection and Copying**. I understand that I may inspect and copy any information used or disclosed under this

Authorization. I understand that I will be charged for any copying services in accordance with applicable law.

8. **Format of Requested Documents**. I request that the documents be released to the recipient(s) in the following format(s):

   - ❑ Physical review of the records within twenty four hours of Atrio Home Health's receipt of this request (excluding weekends and holidays).
   - ❑ Hard copies of the records.
   - ❑ Electronic copies of the records if they exist or Atrio Home Health has the capability to make these.

9. **Release**. I hereby release the facility, its employees, officers, and health care professionals from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized in this Authorization.

10. **Revocation**. I understand that I may revoke this Authorization at any time. This revocation will be in a signed writing delivered to Atrio Home Health. I further understand that the revocation will not take effect until Atrio Home Health receives it and, even then, will be ineffective to the extent that Atrio Home Health has already disclosed the information, otherwise relied on this Authorization, or to the extent that use or disclosure is otherwise permitted or required by law.

11. **Re-disclosure**. I also understand that if the individual or organization authorized to receive this information is not required to comply with current privacy regulations, my health information may be re-disclosed to others and no longer protected by current state and federal privacy regulations.

12. **Authorization Requested by Atrio Home Health**. If Atrio Home Health is seeking this Authorization from the Client for a use or disclosure of the information, Atrio Home Health will provide the Client with a copy of the signed Authorization.

13. **Authority of Representative**. **[Complete only when applicable.]** I am not the Client whose information is to be disclosed. However, I have legal authority to act on behalf of the Client as his or her:

    - ❑ Legal Guardian
    - ❑ Parent of Minor
    - ❑ Patient Advocate Designee
    - ❑ Personal Representative

14. **Full Authorization.** I understand and acknowledge that this Authorization extends to all or any part of the records being requested, which may include treatment for physical and mental illness (except for psychotherapy notes which must be requested by separate authorization); alcohol/drug abuse, and/or HIV/AIDS test results or diagnosis and treatment. Initial here: _____

A description of my authority to act for the Client is as follows:_____

_____

Date:_____ Signature of Client:_____

Printed Name of Client:_____

Date:_____ Signature of Representative:_____

Printed Name of Representative:_____

Relationship to Client:_____

Date:_____ Signature of Witness:_____

Printed Name of Witness:_____