

Authorization To Release Medical Records:

PATIENT INFORMATION:

Name (print) _____ DOB _____ SSN _____

INFORMATION TO BE RELEASED FROM:

Name of facility or provider _____
Address _____

INFORMATION TO BE SENT TO:

Name of designated recipient
RECORDS DEPOSITION SERVICE, INC.
Address _____ City _____ State _____ Zip _____
P.O. BOX 5054 SOUTHFIELD MI 48086-5054

INFORMATION TO BE RELEASED: (check one)

- The most recent 2 years of pertinent information (chart notes, labs, x-rays and special tests)
 All medical records
 Specific information (please specify) : PLEASE SEE ATTACHED SUBPOENA OR LETTER REQUEST

PURPOSE FOR WHICH THE DISCLOSURE IS BEING MADE: (please check one)

- Attorney Insurance Doctor Personal

PATIENT AUTHORIZATION :

I understand that my records may contain information regarding the diagnosis or treatment of HIV/AIDS, sexually transmitted diseases, drug and/or alcohol abuse, mental illness, or psychiatric treatment. I give my specific authorization for these records to be released.

* EXCLUDE the following information from the records released (please initial)

- Drug / Alcohol abuse/treatment & diagnosis Sexually transmitted disease
 HIV/AIDS diagnosis/treatment/testing Mental illness or psychiatric diagnosis/treatment

MY RIGHTS:

I understand I do not have to sign this authorization in order to obtain health care benefits (treatment, payment or enrollment). I may revoke this authorization in writing. To view the process for revoking this authorization, please read the Privacy Notice to patients posted at the facility where your information is being released. I understand that once the health information I have authorized to be disclosed reaches the noted recipient, that person or organization may re-disclose it, at which time it may no longer be protected under Privacy laws.

Signature: _____ Date: _____
(Patient, guardian*, or Authorized representative*)

**This authorization will expire 90 days from the date signed
Possible copying fee required**