DAVID K. VALLANCE, M.D. P.C.
AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

Patient name ______________________________

Patient number ____________________ Patient phone number ____________________

Patient address ______________________________

I authorize the health care facilities and practitioners named below to release health information identifying me (including if applicable, information about HIV infection or AIDS, information about substance abuse treatment, information about genetic testing, and information about social work or mental health services) under the following terms and conditions:

1. Detailed description of the information to be released:
   Please see enclosed Subpoena or Letter Request for information to be disclosed.
2. Health facilities or practitioners authorized to release information (names or classes of entities):
   David K. Vallance, M.D., P.C.
3. To whom may the information be released [name(s) or class(es) of recipients]: P: 248-357-3330
   RECORDS DEPOSITION SERVICE, INC. PO BOX 5054, SOUTHFIELD, MI 48086-5054 F: 248-357-3337
4. The purpose(s) for the release:
   For Discovery Before Trial
5. Expiration date or event relating to the individual or purpose for the release:
   ____

It is completely your decision whether or not to sign this authorization form. The health facilities or practitioners named in this authorization cannot refuse to treat you if you choose not to sign this authorization. Because this authorization is sought in connection with litigation in which you are a party, you may wish to discuss the effect of signing or not signing the authorization with your attorney.

If you sign this authorization, you can revoke it later. The only exception to your right to revoke is if the health facilities or practitioners named above have already acted in reliance upon the authorization. If you want to revoke your authorization, send the health facilities or practitioners named above a written or electronic note telling them that your authorization is revoked. Send this note to the Privacy Officer of the health facility or practitioner. You can obtain this name and contact information from the applicable health facility or practitioner. Because this authorization is sought in connection with litigation in which you are a party, you may wish to discuss the effect of revoking the authorization with your attorney.

With the exception of substance abuse treatment information, mental health information or HIV/AIDS information, when your health information is disclosed as provided in this authorization, the recipient may have no legal duty to further protect its confidentiality. In some cases, the recipient may re-disclose the information as he/she wishes. In litigation, your health information may become part of the public record in the lawsuit.

I have read and understand this form. I am signing it voluntarily. I authorize the disclosure of my health information as described in this form.

Dated ____________________ Patient signature ______________________________

If you are signing as a personal representative of the patient, describe your relationship to the patient and the source of your authority to sign this form:

Relationship to Patient ____________________ Print Name ____________________

Source of Authority ______________________________
(Attach relevant documents, if applicable, such as guardianship papers, power of attorney, for example)