AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____, hereby consent to communication between:

Dawn Farm
P.O. Box 981098
Ypsilanti, MI 48150
(734) 485-8725

and

RECORDS DEPOSITION SERVICE, INC.

PO BOX 5054, SOUTHFIELD, MI 48086-5054 P: 248-357-3330 F: 248-357-3337

Extent or nature of disclosure is limited to: (Check all that apply) HIPAA standards require that you request the minimum information necessary to complete required purpose of this release.

- ☐ Discharge Summary
- ☐ History & Physical
- ☐ Mental Health Assessment
- ☐ Treatment Plan
- ☐ Physician Orders
- ☐ Dates in program
- ☒ Other(Please be specific): **ENTIRE FILE**

Purpose of need for disclosure is: **FOR DISCOVERY BEFORE TRIAL**

I understand that my alcohol and/or drug treatment records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 C.F.R. Pts. 160 & 164 and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically as follows:

_____

(Specification of the date, event, or condition upon which this consent expires)

I understand that I might be denied services if I refuse to consent to a disclosure for purposes of treatment, payment, or health care operations, if permitted by state law. I will not be denied services if I refuse to consent to a disclosure for other purposes.

I have been provided a copy of this form.

Client Signature: _____ Date: _____

Witness Signature: _____ Date: _____