4535 Dressler Rd. W, Canton, OH 44718
1-800-982-8177 Fax (330) 492-8489

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION
45 CFR §164.508

Federal and State law, including the Health Insurance Portability and Accountability Act ("HIPAA"), requires health care providers to protect your health information. EMP Management Group, Ltd. ("EMP") provides billing and management services for affiliated or contracted healthcare providers, who provide EMERGENCY MEDICINE, OBSERVATION and HOSPITALIST medical services. This form authorizes the release of your billing records and statements for treatment you received. If you need a copy of your medical record or chart, those must be obtained from the hospital's medical record department where you received treatment.

Print Patient Name:____

I authorize the release and disclosure of my Protected Health Information ("PHI") under the restrictions and conditions in this Authorization form.

1. Person or persons, entity or entities who may disclose my Protected Health Information:
   - ☑ a. EMP Management Group, Ltd., and/or its employees or agents, and includes the treating EMP physician or other health care provider.
   - ☐ b. Specific person (specify): ______________________________
2. The following PHI may be released or disclosed:
   - ☐ a. Billing and medical records for medical services received by me (check and complete only one):
     - ☐ Date of medical treatment for illness, injury, or accident on: ____________ (date).
     - ☐ Dates of medical treatment for illness, injury or accident from: ____________ (date) to: ______________ (date).
     - ☐ At any and all times and dates treated.
   - ☑ b. Other (specify): PLEASE SEE ATTACHED SUBPOENA OR LETTER REQUEST
3. The PHI specified in this Authorization may be released and/or disclosed to the following individual(s) and/or organizations (such as carriers, insurance companies, lawyers, law firms, etc.): **MUST BE FILLED OUT**
   RECORDS DEPOSITION SERVICE, INC. P.O. BOX 5054, SOUTHFIELD, MI 48086-5054
   P: 248-357-3330 F: 248-357-3337
4. I am authorizing disclosure of my PHI for the following purpose(s):
   - ☐ a. Assist in payment or reimbursement of my health care expenses.
   - ☑ b. Assist in pursuing or defending a lawsuit, prosecution, or other legal proceeding.
   - ☐ c. Other: ______________________________
   - ☐ d. At my request. (Check this if you prefer not to give your reason for authorizing disclosure of your PHI.)

5. I understand that this Authorization may include disclosure of information relating to alcohol and drug abuse, mental health treatment (except psychotherapy notes), genetic testing information, and confidential AIDS/HIV related information. IF I INITIALED below, EMP should NOT disclose this subject matter related information unless further authorization is obtained:

   Initials

   ________ (a) HIV/AIDS related information and/or records

   ________ (b) Mental health information and/or records (*except psychotherapy notes*)

   ________ (c) Genetic testing information and/or records

   ________ (d) Drug/alcohol diagnosis, treatment and referral information

6. I understand that if whoever receives my Protected Health Information (PHI) is not a health care provider or health plan covered by federal privacy regulations, the disclosed information may be redisclosed and is no longer protected by those regulations. I release any and all parties permitted to disclose my PHI by this Authorization, and their employers and staff, from all liability arising from the disclosure of my PHI under this Authorization.

7. I understand that I have the right to revoke this Authorization, in writing, at any time by sending written notice to: Privacy Officer, 4535 Dressler Road NW, Canton, OH 44718. I understand that a revocation is not effective to the extent that action has already been taken in reliance upon this Authorization.

8. I understand that I may refuse to sign this Authorization and that my refusal to sign will not affect my ability to obtain treatment, payment or my eligibility for benefits.

9. This Authorization will expire automatically in six (6) years, or earlier if one of the following occurs before the six years is up: (Leave both blank if you want the Authorization to be in force for the maximum of six years.)

   a. Specific date: ______________________ (must be less than six years from date signed).

   b. Specific event: ______________________________________. (Example, a lawsuit is settled)

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Print Patient's Name

Address of Patient:

____

____

Social Security No.: __________________________

Account No.: ______________________________

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Signature of Patient

Date Signed: ______________________________

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Print Name of Patient's Personal Representative/Guardian

Address of Personal Representative/Guardian:

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Description of Representative's Authority to Act for the Patient:

- ☐ Parent
- ☐ Medical Power of attorney/representative
- ☐ Legal guardian
- ☐ Health care surrogate
- ☐ Other; specify ______________________

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Signature of Personal Representative/Guardian

Date Signed: ______________________________