MERCYHEALTH

Authorization to Use, Disclose or Release Health Information

This form must be complete to be processed

Patient Name: _____ Soc. Sec. #:_____

Telephone Number: _____ Date of Birth: _____

1. I authorize _____(Facility name) to use, disclose or release the following protected health information about the above named patient: (includes dates below)

   ❑ entire record; **OR**
   If less than the entire record, each of the following components indicated by a checkmark:

   ❑ history and physical
   ❑ discharge summary
   ❑ laboratory results
   ❑ ER dictation
   ❑ operative report
   ❑ pathology report
   ❑ x-ray imaging reports
   ❑ physician orders
   ❑ consultation reports from (doctors' names):_____
   ❑ abstract of record (dictated report, all diagnostic testing)
   ☑ Other (Specify what is to be used, disclosed or released): PLEASE SEE THE ATTACHED SUBPOENA OR LETTER REQUEST FOR THE INFORMATION TO BE DISCLOSED

   Treatment from (date) _____ to (date) _____

   Format to receive medical records: ❑paper ☑CD

2. I understand that the information to be disclosed may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral mental health services, and treatment or testing for alcohol or drug abuse.

3. I authorize disclosure of the above listed information to the following individual or organization:
   Name: RECORDS DEPOSITION SERVICE, INC.
   Address: P.O. BOX 5054 City SOUTHFIELD State MI Zip Code 48086-5054
   For the purpose of: LEGAL - FOR DISCOVERY BEFORE TRIAL

4. I understand that I have a right to cancel this authorization, in writing, at any time by presenting my written cancellation to the manager, Health Information Management, or other designated representative, at the entity named above. I understand that a cancellation will not apply to information that has already been released under this authorization. I understand that the cancellation will not apply to my insurance company when the law gives my insurer the right to consent a claim under my policy number

5. Unless I cancel it sooner, this authorization will expire on the following date, event, or condition: _____. If I fail to specify an expiration date, event or condition, this authorization will expire in one year from the date appearing at the bottom.

6. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form to obtain treatment. However, without my signature, information will not be released to the individual or organization named above. I understand that I may inspect or copy the information to be used or disclosed, as provided by the federal government's rules, which are in the United States Code of Federal Regulations at section 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the Mercy Health Privacy Officer Misty Glasgow at 513-624-4072. For questions about the status of your records request, please contact MRO Corp. at 1-888-252-4146. For all other requests contact 513-981-6489, 513-981-6239 or 513-981-6486.

_____
Signature of Patient or Legal Representative Date

If signed by Legal Representative, relationship to patient: _____

You are to receive a copy of this signed authorization to keep for your records. There may be a charge for copies of records.