Preventice SERVICES

888.747.1442 | preventicesolutions.com
1717 N. Sam Houston Parkway West, Suite 100
Houston, Texas 77038

Authorization for Release of Patient Medical Information

To request release of medical information please complete and sign this form and return it by mail or fax to:

Preventice Services, LLC
Attn: Medical Records Department
1717 N Sam Houston Pkwy W, Suite 100
Houston, TX 77038
Fax: 281-760-0332 or 888-432-9522

If you need help completing this form, please contact the Monitoring Center at **888.400.3522**.

Patient Information		
Last Name	First Name	MI
Street Address		Apt. #
City	State	Zip
SSN or MRN	Home Telephone	
Date of Birth	Alternate Telephone	

I hereby authorize Preventice Services, LLC to release reports and other information contained in my Medical Record. I understand this information has already been provided to my ordering physician.

Information Requested (please be specific and enter date of service if known)			
PLEASE SEE ATTACHED SUBPOENA OR REQUEST FOR INFORMATION			
Restrictions and / or Exclusions			
Purpose of Release LEGAL DISCOVERY			

Preventice Services, LLC will provide the information requested above to the following party ONLY:

Name RECORDS DEPOSITION SERVICE, INC.			
Attention To	Telephone 248.357.3330	Fax or Email	248.357.3337 REQUESTS@RECDEP.COM
Street Address PO BOX 5054			
City SOUTHFIELD	State MI	Zip 48086-5054	
Preferred Method of Delivery ☐ Fax ☒ Email ☐ Mail (USPS)			

I hereby authorize Preventice Services, LLC ("Preventice") to release any medical information as requested above. This may include information about arrhythmias, symptoms, activities or other protected health information unless otherwise excluded, except clinician notes. I am aware that Preventice cannot control how the recipient uses or shares the information, and that laws protecting its confidentiality at Preventice may or may not protect this information once it has been disclosed to the recipient.

Information will not be released without a valid signature below. This authorization will expire 90 days from the below signature date. I can, however, revoke this authorization in writing at any time, except to the extent that Preventice has relied upon it. For example, if I revoke this authorization after Preventice has sent requested records, Preventice will not retrieve those records.

I acknowledge that email is not a secure form of communication. Preventice takes steps to ensure the security and privacy of information, including providing encrypted email. If I have requested email as the means by which I would like my medical information provided, then I understand that Preventice will provide this information to me and/or the person I designated above via an encrypted email. I understand that treatment, payment, enrollment or eligibility of benefits may not be conditioned on signing this authorization, and Preventice will continue to provide care for current and future enrollments.

Signature of Patient (if 18 years of age or older) _____ Date _____

Signature of Personal Representative _____ Personal Representative's Title or Role (e.g., Parent, Guardian, Healthcare Power of Attorney, Executor or Administrator) _____ Date _____

Please make a copy of this release for your records.