

HIPAA Authorization To Disclose Protected Health Information

The undersigned hereby authorizes the Wayne County Juvenile Detention Facility ("JDF") to disclose all protected health information in its files concerning _____, DOB: _____, ("Resident"), including but not limited to medical records, mental health records, patient histories, office notes, test results, radiology studies, referrals, consultations, billing records, insurance records, information regarding communicable diseases and infections, including tuberculosis, venereal diseases, sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV), or AIDS-related complex (ARC), and medical records provided to the JDF by other health care providers. Said protected health information may be disclosed to RECORDS DEPOSITION SERVICE, INC.

P.O. BOX 5054, SOUTHFIELD, MI 48086-5054

P: 248-357-3330

F: 248-357-3337

E: REQUESTS@RECDEP.COM

for the purpose of PRE TRIAL DISCOVERY

With respect to this disclosure, I understand and acknowledge the following:

1. I understand that authorizing the release of this health information is voluntary and that the JDF may not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this Authorization.
2. I have the right to revoke this authorization at any time by writing to the JDF at 1326 St. Antoine, Detroit, MI 48226. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
3. Unless otherwise revoked, this Authorization will automatically expire in 90 days.
4. Information disclosed under this authorization might be redisclosed by the recipient, and this redisclosure may no longer be protected by federal or state law.

Name (Please Print): _____

Signature: _____ Date: _____

Authority to act on Resident's behalf:* _____

*If guardian, attach order of appointment

Authorization to Release Records Waiver of Privilege

The purpose of this Authorization to Release Records/Waiver of Privilege ("Authorization") is to authorize the Wayne County Juvenile Detention Facility ("JDF") to release records **other than those** covered by the Health Insurance Portability and Accountability Act ("HIPAA") and the Federal Educational Records Privacy Act ("FERPA"). Separate HIPAA-compliant and FERPA-compliant authorizations, in addition to this Authorization, will be necessary to obtain records protected by those two Acts.

I hereby give the JDF permission to disclose all information in the JDF's juvenile file for _____, DOB: _____,

("Resident"), to RECORDS DEPOSITION SERVICE, INC.

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other than information for which a release under HIPAA, FERPA, or other statute or regulation is required.

The information I give the JDF permission to disclose includes but is not limited to the following information:

| | |
|-------------------------|-------------------------------|
| Intake forms | Interest inventories |
| Incident reports | Self-assessments |
| Disciplinary records | Visiting records |
| Court records | Reports of neglect or abuse |
| Law enforcement records | Non-privileged communications |

Communications covered by the social worker-client, counselor-client, or other privilege recognized by statute, court rule, or other authority

Communications made or recognized as privileged by the Michigan Mental Health Code, including the doctor-patient, psychiatrist-patient, psychologist-patient, and other health care provider privileges, when this Authorization is accompanied by an executed HIPAA-compliant release

Records made confidential by the Michigan Mental Health Code, when this Authorization is accompanied by an executed HIPAA-compliant release

Records made confidential by the Child Care Organizations Act, 1973 PA 116

I hereby expressly waive any and all statutory or other privileges applicable to the foregoing communications, records, and other information.

Parent or Guardian Information (or Resident Information, if over 18)

Name: _____

Address: _____

Home Phone: _____ Cell: _____ Work: _____

Signature of Parent or Guardian* (or of Resident, if over 18)

Signature: _____ Date: _____

*Attach Order of Appointment as Guardian

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