Authorization for Release of Patient Information

Patient Name: ____________________________ Date of Birth: ____________________

Patient Number/MRN: _____________ Phone Number: _____ -_______-________
(Optional)

I authorize The Wellness Plan or its practice manager, designee or medical record department to release information from my medical records as specified below which may include records of my medical / surgical care; venereal disease information; behavioral health and/or social service information including communication made by me to a psychiatrist, psychologist and/ or social worker: substance abuse information protected under 42 Code of Federal Regulations Part 2 or other information as specified.

1. This information may be disclosed to and used by the following person or organization:

Name or title: RECORDS DEPOSITION SERVICE, INC.

Address: PO BOX 5054

City: SOUTHFIELD State: MI Zip: 48086-5054

Phone #: 248-357-3330 Fax#: 248-357-3337

2. Specific type of information to be released.

☐ Any and All Records ☐ Immunization Report ☐ Problem History
☐ Laboratory Reports ☐ Radiology Reports ☐ Outside Records
☐ Progress Notes ☐ History & Physical ☑ Other (Please Specify Below)

PLEASE SEE ATTACHED SUBPOENA OR LETTER REQUEST

____

3. Time period covered: from ___/___/____(mm/dd/yyyy) to ___/___/____(mm/dd/yyyy).

☐ East Area Health Center 4909 East Outer Drive Det, MI48234/313.366.2000
☐ Northwest Health Center 21040 Greenfield Oak Park, MI48237/248.967.6500
☐ Gateway Medical Center 2888 W Grand Blvd Det, MI48202/313.875.4200
☐ Henderson Medical Center 44405 Woodward Ave Pontiac, MI48341/248.858.3126

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4. The purpose and need for disclosure of information (for example, medical care, insurance, disability, attorney, other):

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5. I authorize the release of communicable or serious communicable disease infection which may be contained in my medical record. Consistent with Michigan Public Act 488 of 1988, this authorization allow for the disclosure of any information in my medical records pertaining to HIV testing, HIV infection, Acquired Immunodeficiency Syndrome (AIDS), AIDS related complex(ARC), venereal disease and/or other communicable or serious communicable disease or infection.
6. This authorization shall be in enforced and effective until ___________________ (date or event), at which time this authorization expires. If left blank authorization expires 1 year after the date of signature.
7. I understand that I have the right to revoke this authorization in writing to The Wellness Plan at any time. I understand that a revocation is not effective to the extent that The Wellness Plan has already acted upon my authorization.
8. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.
9. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Patient Fee List

Per Page for the first 20 pages.... $1.19

Per Page from Pages 21-50.... $ 0.60

Per Page from Pages 51+... $0.23

Attorneys and Insurance Companies

Initial Fee.... $ 23.71

Per Page for the first 20 pages.... $1.19

Per Page from Pages 21-50.... $ 0.60

Per Page for Pages 51+.... $0.23

Patient or Guardian Signature: ________________________________ Date:________________

Relationship to Patient: ________________________________ Date: ________________