

Patient Name _____ Phone Number _____ Medical Record Number _____
Address _____ Date of Birth _____

AUTHORIZATION FOR RELEASE OF PATIENT HEALTH INFORMATION

I hereby authorize that the protected health information regarding the above-named person be forwarded:

FROM: Person/Institution _____
Address _____
City _____ State _____ Zip _____

TO: Person/Institution RECORDS DEPOSITION SERVICE, INC.
(Recipient) Address P.O. BOX 5054 P: 248-357-3330
City SOUTHFIELD State MI F: 248-357-3337
Zip 48086-5054

Purpose or need for information: _____

Disclosure will include: (check all that apply)

- Face Sheet History & Physical Laboratory Report Operative Report Itemized Bill
 Discharge Summary Progress/Physician Notes X-ray/Radiology Report Pathology Report Other PLEASE SEE ATTACHED
 Emergency Report Nurses Notes EKG/EMG/EEG Report Consultation Report SUBPOENA OR LETTER REQUEST

Records for the period (dates) from _____ to _____

I must check one or more of the following types of health information that I do not want released to the above named Recipient. I understand that if I do not check any of the three (3) following boxes, the health information released to the named Recipient may include any of the following:

- _____ **Diagnosis, Evaluation and/or treatment for alcohol and/or drug abuse**
_____ **Records of HTLV-III or HIV testing (AIDS test) result, diagnosis and/or treatment**
_____ **Psychiatric, psychological records or evaluation and/or treatment for mental, physical and/or emotional illness including narrative summary, tests, social work assessment, medication, psychiatric examination, progress notes, consultations, treatment plans, and/or evaluation.**

I also understand that this Authorization is subject to revocation/withdrawal by me at any time in writing to the medical record contact person at this site of care except to the extent that action has already been taken to release this information. This Authorization shall remain valid unless revoked but **will expire in 1 year after signing**. I have a right to inspect a copy of the health information to be released and if I do not sign this Authorization, the institution named above will not release my health information. The above named person/institution will not refuse to treat me based on whether I agree to allow my health information to be used and disclosed to others.

Signature of Patient _____

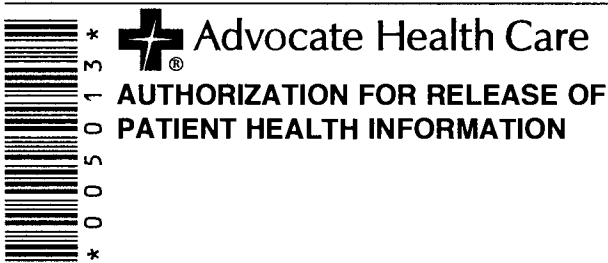
Date _____

Signature of Parent/Legal Guardian/Personal Representative
(Required if Patient is not legally authorized to sign Authorization)

Relationship to Patient _____

Witness _____

REDISCLASURE: Notice is hereby given to the patient or legal representative signing this Authorization that Advocate Health Care cannot guarantee that the Recipient receiving the requested health information will not redisclose any or all of it to others. Notice is hereby given to the Recipient that law prohibits the redisclosure of any health information regarding drug and/or alcohol abuse, HIV and mental health treatment.



Patient Name: _____
MR Number: _____
Patient Number: _____
OR
Affix Patient Label

Patient Name _____

Date of Birth _____

Address _____

Medical Record Number _____

Phone Number _____

AUTHORIZATION FOR RELEASE OF HIGHLY CONFIDENTIAL HEALTH INFORMATION (evaluation, diagnosis, testing and /or treatment for alcohol and/or drug abuse [federally assisted programs], HIV or AIDS and mental health).

I hereby authorize that such health information regarding the above-named person be forwarded:

FROM: Person/Institution _____

Address _____

City _____ State _____ Zip _____

TO: Person/Institution RECORDS DEPOSITION SERVICE, INC.

(Recipient)

Address P.O. BOX 5054 P: 248-357-3330

City SOUTHFIELD State MI Zip 48086-5054
F: 248-357-3337

Purpose or need for information: _____

Disclosure will include the following verbal or written information: *(check all that apply)*

- Face Sheet
- Discharge Summary
- ER Record Report
- Substance Abuse Treatment Record
- History & Physical
- Medication Records
- Psychiatric Evaluation
- Laboratory/Diagnostic Testing Results
- Behavior Health/Psychological Consult
- Psychosocial Assessment
- HIV Test Results
- School Information
- Psychological Evaluation/Testing Results
- Summary of Treatment Records and contact dates
- Other PLEASE SEE THE ATTACHED SUBPOENA OR LETTER REQUEST

Records for the period (dates) from _____ to _____

I have a right to inspect and copy the health information to be released and if I do not sign this Authorization, the institution named above will not release my health information. The above named person/institution will not refuse to treat me based on whether I agree to allow my health information to be used and disclosed to others.

I also understand that this Authorization is subject to revocation/withdrawal by me at any time in writing to the medical record contact person at this site of care except to the extent that action has already been taken to release this information. This Authorization shall remain valid unless revoked.

EXPIRATION DATE: This release is valid for one (1) year from the date signed unless I fill in an early date ____/____/____.

Signature of Patient

Date

OR

Signature of Parent/Guardian/Legal Representative

Date

Relationship to the Patient (See Back of Form)

Witness

Date

REDISCLASURE PROHIBITED: Notice is hereby given to the patient or legal representative signing this Authorization that substance abuse information has been disclosed from records whose confidentiality is protected by Federal law. Federal regulations (42 CRF Part 2) prohibit the recipient from making any further disclosure of this information except with specific written consent of the patient. Notice is hereby given to the recipient that Illinois law prohibits the redisclosure of any health information regarding HIV and mental health treatment without further authorization.



Advocate Health Care

AUTHORIZATION FOR RELEASE OF HIGHLY CONFIDENTIAL HEALTH INFORMATION

