



INSTRUCTIONS: This authorization is made by you for the disclosure of your health information, as indicated. Please complete each section. Sections NOT completed may delay health information from being disclosed.

SECTION 1 - Patient Information
Patient Full Name - First, Middle, Last: Birthdate: Month Day Year
Patient Address - Street/Apt/Suite: City: State: Zip:
Phone Number: Fax Number: Social Security Number (Last 4) OFFICE USE ONLY: Patient MRN/Encounter Number

SECTION 2 - Disclosure of Health Information

I authorize _____ to Disclose Obtain Disclose and Obtain
(facility name)

Disclose To

Name of Facility/Entity/Individual: RECORDS DEPOSITION SERVICE, INC
Street Address/Apt/Suite: PO BOX 5054 City: SOUTHFIELD State: MI Zip: 48086-5054
Phone Number: 248.357.3330 Fax Number: 248.357.3337

Obtain From

Name of Facility/Entity/Individual:
Street Address/Apt/Suite: City: State: Zip:
Phone Number: For Direct Patient Care Only - Fax Number:

SECTION 3 - Purpose Of Disclosure

- Legal School Further Care/Treatment Transfer/Placement
Insurance Personal Use Other (specify)

SECTION 4 - Requested Format

- Paper Electronic Media Verbal Disclosure (For Use in Behavioral Health Programs Only)

SECTION 5 - Delivery Method

- Mail Pick-Up Fax Secure Email (email address) INFO@RECDEP.COM Verbal Disclosure (For Use in Behavioral Health Programs Only)

SECTION 6 - Dates of Treatment

Dates of treatment to be disclosed (i.e. specific date 1/25/15; or a range of dates Jan-July 2017):

SECTION 7 - Medical/Surgical Health Information To Be Disclosed - Check All That Apply

- Record Abstract (History and Physical, Emergency Room Record, Lab, Radiology, Operative Report, Pathology Report, Consultation Report, D/C Summary and other diagnostic tests).
Emergency Report Clinic Notes (specify clinic)
History and Physical(s) Rehab or Therapy Notes (specify type)
Consultation(s) Prenatal Summary
Progress Note(s) Entire Chart
Operative/Procedure Report(s) Itemized Bill
Laboratory Results Other (specify) PLEASE SEE ATTACHED SUBPOENA OR REQUEST FOR INFORMATION
Pathology Results Discharge Summary
Radiology Report(s)
Radiology films/digital images
EKG/Stress Test(s)

Authorization for Release of Patient Health Information



