Authorization for Access, Use and/or Disclosure of Protected Health Information

1. **I hereby request that** _____ **(enter name of entity providing access or disclosure).**

   ☐ Allow me access to the information requested below
   ☐ Provide me with my own copy of the information requested below (circle format you would like: photocopy, electronic, other:_____)
   ☒ Disclose the information requested below to the individual or entity listed In item #3

2. **Reason for request:** For Discovery Before Trial

3. **Disclose the information to the following individual or organization:**
   Name: RECORDS DEPOSITION SERVICE, INC.
   Address: 120 W. MADISON STREET, STE. 300 City: CHICAGO State: IL
   Zip Code: 60602 Phone #: 312-553-8900 Fax#: 312-553-8901

4. **Specify description of information to be accessed and/or disclosed:**

☐ **My medical records**
   ☐ Complete medical record (except for mental health and/or developmental disability, substance abuse, and/or HIV/AIDS-related information; must be checked separately)
   ☐ Abstract (face sheet, history and physical, operative report, discharge summary, consults)
   ☐ Surgical (operative report, pathology report)
   ☐ Tests results (lab, radiology, cardiology, neurophysiology, respiratory)
   ☐ Mental health and developmental disability records
   ☐ Substance abuse records
   ☐ HIV/AIDS – related information records
   ☐ Therapy note: Physical,Occupational, Speech, and/or Respiratory Therapy
   ☒ Other: Please see enclosed Subpoena or Letter Request for information to be disclosed.

☐ **My billing records**

☐ **Any other personally identifiable information used to make medical decisions about me.**
   Please describe:_____

5. **Request access and/or disclosure of records for the following dates of service:**

   _____

   _____

I have read and understand the following statements:

I understand this Authorization will expire on (/ /) or when the following event occurs:

_____

Note: If authorization is for disclosure of mental health records, it must have a calendar date expiration or the information may only be disclosed on the current day.
Note: If this authorization is for research, an expiration date is not required.

- I understand that _____ may be allowed by law to refuse to allow access to or disclosure of all or part of my protected health information. If access or disclosure is denied or refused, _____ will not release the information as requested in this Authorization, and I will be notified of the denial/refusal in writing.
- I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this Authorization. I understand that _____ will not condition treatment, payment, enrollment in any health plans or my eligibility for benefits if I decide not to sign this Form.
- I understand that I may revoke this Authorization at any time by notifying _____ in writing, but if I do, it will not have any affect on any actions _____ took before it received the revocation.
- I understand that there is potential for information disclosed based on this authorization to be subject to re-disclosure by the recipient and no longer be protected by the Privacy Rule.
- I understand requests may be subject to a copying fee.
- I understand that I may see and copy the information described on this form if I ask for it, and that I shall receive a copy of this form after I sign it if the request for disclosure was initiated by _____.

If this Authorization Form authorizes use and/or disclosure of psychotherapy notes it may not be used to authorize the use and/or disclosure of any other protected health information.

_____ ____/____/____
Printed Name of Patient **Date**

_____ ____/____/____
Patient (or *Legal Representative) Signature **Date**

_____ ____/____/____
Witness **Date**

***Please attach court order or other documentation designating the legal representative, as applicable.**

Note to the recipient of alcohol or drug abuse records: This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.