I authorize the following CHS	Facility(s):	Community Hospital	St. Catherine Hosp		St. Mary Medical Center	
To release information from	the record of:	My Chart	Other			
AUTHOR	IZATION FOR	USE AND DISCLOSURE	OF PROTECTED HEAL	TH INFORM	MATION	
Patient Name			Phone Number	Phone Number		
Address			Date of Birth	Date of Birth		
City			Social Security N	umber		
State, Zip Code	Zip Code		and the state of t		(last 4 digits only)	
THIS INFORM	MATION IS TO	BE RELEASED TO THE	FOLLOWING INDIVIDU	JAL OR OR	GANIZATION	
Name of Person or Facility	RECORD:	S DEPOSITION S	ERVICE. INC.		NO ENVIOLENCE SERVICE	
Address		5054, SOUTHFIE		- 1	: 248-357-3330 F: 248-357-3337 IFO@RECDEP.COM	
Records are requested for th	ne purpose of:	Continuing Care	☐ Insurance	✓ Lega		
Requested Format:		Paper	✓ Electronic	☐ CD		
The Information I authorize	disclosed is:					
☐ Designated Record Set (☐ Other PLEASE SEE I understand that my health syndrome (AIDS), or human and treatment for alcohol and	oduction of pho medical records ATTACHED S record may incl immunodeficien nd drug abuse.	Nu Ar	e providers)  ER REQUEST  to sexually transmitted so include information a	disease, acc	quired immunodeficiency ioral or mental health services	
writing to the Health Information released in response to this provides my insurer with the	mation Managers authorization. te right to conte condition:	ment Department. I un I understand that the est a claim under my pol	derstand that the revoc revocation will not app icy. Unless otherwise re	cation will n ly to my ins evoked, this	this authorization I must do so tot apply to information alrea surance company when the la authorization will expire on t date, event or condition, to	
that I may inspect or copy	the information recipient and no ntact the Health	to be used or disclosed o longer protected by fee Information Manageme	I understand informat deral privacy regulations	tion disclose s. If I have o	this authorization. I understand pursuant to this authorization about disclosure of response to the state of	
I authorizeable to prove their identity	with a valid driv	to pick up the er's license or state ident	requested copies of my ification card.	record and	understand that he/she must	
Signature of Patien	t or Legal Repre	sentative		Date		
Parent or Legal Guardia	n Next	of Kin of Deceased	Power of Attorne	y Ex	ecutor of Estate	

Rev: 01/29/13