MILLENNIUM™
LABORATORIES
because pain matters

ATTN: LEGAL DEPARTMENT

AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION

I, _____, authorize Millennium Laboratories to disclose health information about me as described below to

RECORDS DEPOSITION SERVICE, INC. 120 W. MADISON ST., SUITE 300
CHICAGO, IL 60602 P: 312-553-8900 F: 312-553-8901

1. The health information that may be used and disclosed includes (e.g., billing or claims information, lab test results):

PLEASE SEE ENCLOSED SUBPOENA OR LETTER
REQUEST FOR INFORMATION TO BE DISCLOSED

In addition, to protect your privacy, the following types of information will be disclosed only if specifically authorized by you by checking and initialing the appropriate box below.

☐ Drug/Alcohol Information_____*(initial)*

☐ Psychiatric Information_____*(initial)*

☐ HIV/AIDS_____*(initial)*

☐ Sexually Transmitted Diseases/ Communicable Disease_____*(initial)*

☐ Pregnancy/Family Planning_____*(initial)*

☐ Genetic Test Records and/or other Genetic Information_____*(initial)*

☐ Other:_____

☐ Exclusions:_____

Applicable Date Range(s): _____

_____

2. This disclosure is being made for the following purposes:

FOR DISCOVERY BEFORE TRIAL

_____

3. I understand that this Authorization is voluntary and that my treatment, payment for treatment, health insurance enrollment or eligibility for benefits will not be affected if I refuse to sign this form, but if I do not sign this Authorization, Millennium Laboratories cannot disclose health information about me.

4. I understand that I may change my mind and revoke (take back) this Authorization at any time in writing by sending written request to Millennium Laboratories at 16981 Via Tazon, San Diego, CA 92127. Revoking this Authorization will prohibit further disclosure of my health information by Millennium Laboratories; however, revoking this Authorization will not affect information disclosed by Millennium Laboratories prior to the revocation.

5. I understand that once my health information has been disclosed, the recipient may further disclose this information and federal privacy laws may no longer protect the information from further disclosure.

6. Unless I revoke it, this Authorization expires (ends) on the following date: ___/___/_____

7. I may obtain a copy of this Authorization to keep for my records.

Signature of Patient or Legal Representative (if applicable)	Date
Patient's Date of Birth	
Print Name of Patient or Legal Representative (if applicable)	Legal Representative's Relationship to Patient (if applicable)