Patient Name: *(Please Print)* _____

Address: _____

City/State/Zip: _____

Birth Date: _____ Phone #: _____

I, _____, do hereby authorize ☐ Northwest Community Hospital/Day Surgery Center ☐ Northwest Community Medical Group ☐ Other: _____

To release to: Agency/Facility/Person: RECORDS DEPOSITION SERVICE, INC.

Address: PO BOX 5054

City/State/Zip: SOUTHFIELD, MI, 48086-5054

Phone: 248-357-3330 Fax number: (for physician faxing only) 248-357-3337

For the purpose(s) of: ☐ Continuity of Care ☐ Attorney/client relationship ☐ Insurance ☐ Request of patient ☐ Other

Records for the period (dates) from _____ to _____

Release the Following Information:

| | | | | | |
|---|---|---|---|---|---|
| ☐ Discharge Summary | ☐ Pathology Report(s) | ☐ Emergency Record(s) | ☐ History and Physical | ☐ Abstract (Document Summarizing Health history and Pertinent Information) | ☐ Social History |
| ☐ Radiology Report(s) | ☐ Itemized Billing Statement | ☐ Consultation(s) | ☐ Lab Report(s) | | ☐ PT/OT/Speech |
| ☐ Operative Report(s) | ☐ Cardiology Report(s) | ☐ Progress Notes | ☐ Treatment Plan(s) | | ☐ Psych Evaluation |
| ☑ Other Records as specified: PLEASE SEE ATTACHED SUBPOENA OR LETTER REQUEST | | | | | ☐ Discharge Medication List |
| ☐ Entire Medical Record (Except for Records Concerning Highly Confidential Information mentioned below). | | | | | ☐ Films/CD |

***I also authorize the release of the following:*** ☐ ***Alcohol/Drug abuse diagnoses and treatment records*** ☐ ***Records of HIV/Aids testing, diagnoses or treatment*** ☐ ***Mental Health records*** ☐ ***Genetic Testing. (Check all that apply).***

*I acknowledge that I have the right to revoke this authorization. I understand that my revocation must be in writing. I also understand that my revocation will be valid except to the extent that the person(s) or organization(s) authorized to make the requested use/ disclosure have taken action in reliance on this authorization or if this authorization was obtained as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest the claim under the policy or the policy itself.*

*I understand that I have the right to inspect and copy my information that will be used or discussed pursuant to this authorization. I understand I have a right to receive a copy of this authorization.*

Patient's Signature: _____ Date: _____

Signature of Minor (12-17 inclusive): _____ Date: _____
(mental health or emancipated minor)

Parent/Guardian/Representative Signature: _____ Date: _____

Relationship to Patient: _____

I attest to the identity of the above signature(s):

Witness: _____ Date: _____

**Applicable fees will be charged for patients and attorneys. (735 ILCS 5/8-2006)**

*Under the provisions of HIPAA and under the Illinois Mental Health and Developmental Disabilities Confidentiality Act, authorization for release/disclosure is voluntary. Individuals are not coerced into signing an authorization but provide the information freely. The above-named facility may not limit or restrict services, treatment or care based on the signing of this authorization. Once information is received by the authorized agency/facility or person it may be subject to re-disclosure by the recipient and may no longer be protected by federal privacy laws. Illinois law prohibits re-disclosure of HIV, alcohol, drug abuse and genetic information by the recipient except as otherwise allowed by law. Federal regulations prohibit the recipient from making further disclosure of alcohol and drug abuse patient records except by express written consent of the patient. 42 C.F.R. Part 2. This authorization will automatically expire one year after the date of signing if no prior notice for revocation is received. All original films must be returned in 15 days. The above-named individual has requested the above records to be sent to the agency/facility/person named herein and that it not be further disclosed or used for any purpose other than as stated in this authorization. Any person who discloses mental health records and communication without proper consent/authorization may be subject to civil liability or criminal penalty according to 740 ILCS 110.*

**Northwest Community Hospital**
**Northwest Community Day Surgery Center**
**Northwest Community Medical Group**
Phone: 847.618.4950
Fax: 847.618.3249


**AUTHORIZATION FOR USE or DISCLOSURE OF INFORMATION** Form # 001.070-11/15-1-PS

NCH Item # 41155