## HIPAA AUTHORIZATION FORM

atient's Full Name		Patient's Social Security Number/Medical Record Number	
ldres	s -	Patient's Date of Bir	th
lity, State Zip Code		Patient's Telephone Number	
ereby authorize use or disclosure of protected health inform		nation about me as described below.	
1.	<ol> <li>The following specific person/class of person/facility is authorized to use or disclose information about me:</li> </ol>		
2.	2. The following person (or entity) is authorized to request my protected health information subject to the limitations below:  RECORDS DEPOSITION SERVICE, INC.  His/her/its Name		
	P.O. BOX 5054		
	Address		
	SOUTHFIELD, MI 48086-5054		
	City, State Zip Code		
	REQUESTS@RECDEP.COM E-mail address		
3.	The specific information that should be disclosed is (please give dates of service if possible):		
P	LEASE SEE THE ATTACHED SUB	POENA OR LETTER REOLL	FQT
<del></del>	I authorize the disclosure of the following types of HIV/AIDS testing and treatment:	highly sensitive information: drug a	nd alcohol; mental health (psychiatric);
4.	I understand that by signing this authorization my treatment, payment and enrollment in a health plan or eligibility for benefits will not be conditioned upon my authorization of this disclosure.		
5.	I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal privacy regulations.		
6.	I may revoke this authorization by notifying in writing of my desire to revoke it. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions		
7. 8.	My purpose/use of the information is for <u>LEGAL - FOR DISCOVERY BEFORE TRIAL</u> .  This authorization expires on, 20, OR upon occurrence of the following event that relates to me or to the purpose of the		
wit inv	intended use or disclosure of information about me EES FOR COPIES: Federal and state laws permit th CIOX Health to make copies. You may be required.  FORM MUST BE FULLY COMPLETED BE	a fee to be charged for the copying of p ired to pre-pay for the copies; if not, th	en your copies will be mailed along with an
1 10000	Signature of Individual* The person about whom the information relates) a, if applicable –	Date of Individual's Signature	Date of Birth or Social Security Number
-	Signature of Guardian* or Personal Representative of Patient's Estate	Date of Guardian's/Personal Representative's Signature	Description of Authority to Act for the Individual
	A copy of this completed, signed a	nd dated form must be given to the Ir	ndividual or other signator.
		Official Use Only	
<del>- 100</del>	Received	Processed By	Log #