Steinberg Diagnostic
Medical Imaging Centers
"Where Imaging Revolves Around You"℠

Patient Authorization to Use or Disclose Protected Health Information

I. Patient Name: _____ **Date of Birth/SSN:** _____

I understand by signing below I am authorizing Steinberg Diagnostic Medical Imaging (SDMI) to disclose my protected health information as described to the recipients listed below.

II. I authorize the persons below to receive my protected health information:

Name of Person/Facility: Records Deposition Service, P.O.Box 5054, Southfield, MI 48086-5054 P (248) 357-3330 F (248) 357-3337 E requests@recdep.com

III. Purpose of the release of PHI:

legal discovery

IV. Information to be used or disclosed *(check all that apply):*

☐ Complete Medical Record	☐ Billing Statement _____
☐ Specific Condition _____	☐ Specific Date of Service: _____
☐ Other (specify): _____	

I understand and agree that the information that I am authorizing may include

☐ AIDS/HIV Results ☐ Genetics Testing ☐ Drug Screen Results &Information ☐ Mental Health Information

V. I understand and agree that this authorization is voluntary and I may refuse to sign this Authorization. I further understand that my treatment will not be affected if I do not sign this form. I understand that when the information is used or disclosed, pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the Federal HIPAA privacy rule.

I further understand that I may revoke this Authorization at any time by notifying SDMI in writing, ALL revocations are not effective until received by the Compliance Office except to the extent that action has been taken in reliance on it. Unless earlier revoked this authorization shall expire on _____ or after third party claims have been paid or satisfactorily resolved, whichever occurs last. After this date, Steinberg Diagnostic Medical Imaging Centers can no longer use or disclose the protected health information without first obtaining a new authorization form.

I release SDMI and its agents, representatives, employees from any and all liability associated with the release of confidential patient information in accord with this Authorization. I understand SDMI cannot be responsible for use or re-disclosure of information to third parties. (45 C.F.R. 164.508(c)(2)).

To the receiving party: This information has been disclosed to you for the sole purpose stated in this Authorization. Any other use of this information without the express written consent of the patient is prohibited. These records may be protected by federal regulation.

I fully understand and accept the terms of this authorization.

_____ _____

Print Name and Relation to Patient Date

_____

Patient/Other Legally Authorized Person Signature

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RECORD RELEASE TO A THIRD PARTY

Patient Name: _____ **Date of Birth:** _____

I understand by signing below I am authorizing Steinberg Diagnostic Medical Imaging (SDMI) to disclose my protected health information as described to the recipients listed below. I understand and agree that this authorization is voluntary and I may refuse to sign this Authorization. I further understand that my treatment will not be affected if I do not sign this form. I understand that when the information is used or disclosed, pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the Federal HIPAA privacy rule.

□ Test Results only
□ Complete Medical Record
□ Date Specific Portions of my medical record From:_____ To: _____

In accordance to the Final Omnibus Rule 2013, I need to provide the following info:

Please release my records to:

Name of Person/Facility: Records Deposition Service

Address: P.O. Box 5054, Southfield, MI 48086-5054

☒ Mail Third Party a copy of my records to the above address

□ Third Party will pick up records

I release SDMI and its agents, representatives, employees from any and all liability associated with the release of confidential patient information in accord with this Consent. I understand SDMI cannot be responsible for use or re-disclosure of information to third parties.

_____
Print Name and Relation to Patient

_____ _____
Patient/Other Legally Authorized Person Signature Date

Office Use Only: MRN_____