

Side A

☐ EAST AREA HEALTH CENTER, 4909 E. Outer Drive, Detroit, MI 48234	(313) 366-2000
□ NORTHWEST HEALTH CENTER, 21040 Greenfield, Oak Park, MI 48237	(248) 967-6500
GATEWAY HEALTH CENTER, 2888 W. Grand Blvd., Detroit, MI 48202	(313) 875-4200
TIE BONNER HEALTH CENTER, 10101 Ferkell, Detroit, MI 48238	(313) 401-4300

and Re					
	COMMUNICABLE OR	OR THE RELEASE OF	F INFORMATION RE	GARDING CONTRACTOR	
		BE CONTAINED IN I			
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, (PATIENT NAME					***************************************
(PAHENI NAME	=)	(SOC. SEC. NO.)	(BIRTH DA	(E)	(HPID)
authorize the following	· (hosnital clinic	anency echool	other)		
autitorize the following	i (nospital, chine	, agency, school	, outer)		
		No.)		
MEDICAL DEC	ORD DEPARTMENT	P	1		
THE WELLNES	OF DIAM	<u> </u>			
INE WELLINES	NO PLANT		İ		
2668 W. GRAN					
DETROIT, MICH	THUMN 40202	ls			
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	the desirement is the interpretar				
or its director, designe	a or madical raco	rd danartmant to	rologge inform	ation regarding of	mmumicable or
serious communicable					
lines 2 thru 5 below. Con	nsistent with Michig	gan Public Act 48	8 of 1988, this au	thorization allow fo	or the disclosure
of any information in my					
Syndrome (AIDS), AIDS			i disease and/o	r otner communic	able or serious
communicable disease	or infection when	so specified.			
		•			
1. Party to whom inforn	nation is to be rele	ased:			
·					
Name or title	e pecopo	e DEDOCITION CEI	DVICE INC		
Haile of the	ILLOUILD	S DEPOSITION SER			
		ADISON ST., STE. 3	300		
Address), IL 60602			
	P: 312.55	3.8900 F: 312.553.	8901		
City Chata 7	7:				
City, State, 2	21 p				
2. Specific type of infor	mation to be relea	sed (for example	gonorrhea HIV	infection AIDS re	lated complex.
herpes, other.) Patier					
		line or specify, in	nis or ner own	nandwriting, the ty	pe of
information to be rele	eased.				
3. Time period covered			20 thr	Ш	20
•		***************************************	***************************************		
4. The purpose and nee	ed for disclosure o	f information /for	evamnla medic	al care incurance	disability
	sa ioi disclosure o	i illioilliation (ioi	example, meur	ai care, misurance,	, disability,
attorney, other):					
5. This authorization sh	nali nave a duratioi	n no longer than	that which is rea	isonabiy necessar	y to effectuate
the purpose for whic	ch it is given, and u	inless revoked by	/ me in writing p	rior to this time, w	ill expire
automatically for the	reason(s) specifie	ed below:	•	-	•
,					
Data					
Date					
Event					
Condition					

	SIGNATURES	
PATIENT OR GUARDIAN	>	DATE
WITNESS	\rangle	DATE



Side B

☐ EAST AREA HEALTH CENTER, 4909 E. Outer Drive, Detroit, MI 48234	(313) 368-200
☐ NORTHWEST HEALTH CENTER, 21040 Greenfield, Oak Park, MI 48237	(248) 967-650
GATEWAY HEALTH CENTER, 2888 W. Grand Blvd., Detroit, MI 48202	(313) \$75-420
THE BONNER HEALTH CENTER 10101 Fenkell Detroit MI 48238	(313) 401:430

uthorize the following: (hospital, clinis, agency, school, other) MEDICAL RECORD DEPARTMENT THE WELLNESS PLAN 2888 W. GRAND BLVD. DETROIT, MICHIGAN 48202 or its director, designee or medical record department to release information from my medical records as pecified below which may include records of my medical/surgical care; venereal disease information; sychiatric, psychological and/or social services information including communication made by me to a sychiatrist, psychologist and/or social worker; substance abuse information protected under 42 Code of ederal Regulations Part 2 or other information as specified. Party to whom information is to be released: Name or title RECORDS DEPOSITION SERVICE, INC. 120 W. MADISON ST., STE. 300 CHICAGO, IL 60602 P: 312.553.8900 F: 312.553.8901 City, State, Zip 2. Specific type of information to be released (for example, medical, mental health, social services, other):	AU	THORIZATION FOR RELEAS	E OF MEDIC	AL INFORMATION	
uthorize the following: (hospital, clinic, agency, school, other) MEDICAL RECORD DEPARTMENT THE WELLNESS PLAN 2988 W. GRAND BLVD. OETROIT, MICHIGAN 48202 It its director, designee or medical record department to release information from my medical records as pecified below which may include records of my medical/surgical care; venereal disease information; sychiatric, psychological and/or social services information including communication made by me to a sychiatrist, psychologist and/or social worker; substance abuse information protected under 42 Code of ederal Regulations Part 2 or other information as specified. Party to whom information is to be released: Name or title RECORDS DEPOSITION SERVICE, INC. 120 W. MADISON ST., STE. 300 CHICAGO, IL 66662 P: 312.553.8900 F: 312.553.8901 City, State, Zip Specific type of information to be released (for example, medical, mental health, social services, other): The purpose and need for disclosure of information (for example, medical care, insurance, disability, attorney, other): This authorization shall have a duration no longer than that which is reasonably necessary to effectuate the purpose for which it is given, and unless revoked by me in writing prior to this time, will expire automatically for the reason(a) specified below: Date Event					
MEDICAL RECORD DEPARTMENT THE WELLNESS PLAN 2868 W. GRAND BLVD. DETROIT, MICHIGAN 48202 Ir its director, designee or medical record department to release information from my medical records as pecified below which may include records of my medical/surgical care; venereal disease information; sychiatric, psychological and/or social services information including communication made by me to a sychiatrist, psychological and/or social worker; substance abuse information protected under 42 Code of sederal Regulations Part 2 or other information as specified. Party to whom information is to be released: Name or title RECORDS DEPOSITION SERVICE, INC. 120 W. MADISON ST., STE. 300 CHICAGO, IL 06602 P: 312.553.8901 City, State, Zip S. Specific type of information to be released (for example, medical, mental health, social services, other): Time period covered 20 thru 20 The purpose and need for disclosure of information (for example, medical care, insurance, disability, attorney, other): The purpose for which it is given, and unless revoked by me in writing prior to this time, will expire automatically for the reason(s) specified below: Date Event	(PATIENT NAME)	(SOC. SEC. NO.)		(BIRTH DATE)	(HPID)
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r its director, designee or medical record department to release information from my medical records as pecified below which may include records of my medical/surgical care; venereal disease information; sychiatric, psychological and/or social services information including communication made by me to a sychiatrist, psychologist and/or social worker; substance abuse information protected under 42 Code of sederal Regulations Part 2 or other information as specified. Party to whom information is to be released: Name or title RECORDS DEPOSITION SERVICE, INC. 120 W. MADISON ST., STE. 300 Address CHICAGO, IL 60602 P: 312.553.8900 F: 312.553.8901 City, State, Zip Specific type of information to be released (for example, medical, mental health, social services, other): The purpose and need for disclosure of information (for example, medical care, insurance, disability, attorney, other): The purpose for which it is given, and unless revoked by me in writing prior to this time, will expire automatically for the reason(s) specified below: Date Event	MEDICAL RECO	PLAN		_	
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RECORDS DEPOSITION SERVICE, INC. 120 W. MADISON ST., STE. 300 CHICAGO, IL 60602 P: 312.553.8900 F: 312.553.8901 City, State, Zip 2. Specific type of information to be released (for example, medical, mental health, social services, other): 3. Time period covered	•	it is to be released.			
Address CHICAGO, IL 60602 P: 312.553.8900 F: 312.553.8901 City, State, Zip Specific type of information to be released (for example, medical, mental health, social services, other): Time period covered	Name or title	RECORDS DEPOSITION S	ERVICE, INC.		
Specific type of information to be released (for example, medical, mental health, social services, other): Time period covered	Address	CHICAGO, IL 60602			
Time period covered	City, State, Zip				
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Event	the purpose for which it is	s given, and unless revoke	han that wh	ich is reasonably n writing prior to this	ecessary to effectuate time, will expire
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	SIGNATURES	
PATIENT OR GUARDIAN	>	DATE
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