AUTHORIZATION FOR THE RELEASE OF INFORMATION TO AN ATTORNEY OR LAW FIRM

RE: _____

TO: ANTHEM BLUE CROSS / BLUE SHIELD
9 PINE STREET, 14TH FLOOR
NEW YORK, NY 10005

I request that you kindly furnish RECORDS DEPOSITION SERVICE, INC., PO BOX 5054, SOUTHFIELD, MI, 48086-5054 with copies of any and all records pertinent to reimbursement for the medical expenses of _____ for the period from _____ to _____. Name of the Patient

Purpose of this Authorization (check all that apply):
✔ At the request of the member For the purpose of filing a complaint, grievance, or appeal on my behalf.
For the following purposes[s]: PRE TRIAL DISCOVERY

I understand that this information is confidential and will only be released as specified on this authorization. This authorization is Valid from _____, 20___, or until the records have been furnished as requested.

I also understand that by making this request, I am also authorizing the release of AIDS and/or HIV related information, drug and alcohol treatment related information, and mental illness related information, if any, contained in my records. I know that I may revoke this authorization at anytime except to the extent that action has been taken in reliance upon it by submitting a request in writing. This authorization is limited to obtaining insurance reports and records. It expressly does not permit interviews, consultations or discussions and does not permit any verbal contact.

INITIAL HERE

Except as set forth below, I understand that it is possible that the person or organization I have named to receive this information may re-disclose the information and, if so, the information may no longer be protected by all federal and state laws and regulations, including the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rules.

Exact copies of all records furnished pursuant to this authorization are to be furnished to Records Deposition Service, PO Box 5054, Southfield, MI, 48033 ,for which we agree to reimburse you for your reasonable expenses in doing so.

_____
Date

_____ _____ _____
Signature of Patient Member Identification Number Member Date of Birth

_____ _____
Signature of Parent of Minor Child, Guardian, Conservator or Authorized Representative (when required)

Authority of person signing
(*e.g. Parent, Guardian, Conservator*)

STATE OF _____, COUNTY OF_____}S.S.;

On the_____ day of _____, 20_____, before me personally came and appeared _____to me known and known to me to be the individual described in and who executed the foregoing instrument, and who duly acknowledged to me that (s)he executed the same.

_____
Notary Public

NOTICE TO RECIPIENT OF INFORMATION

This information has been disclosed to you from records the confidentiality of which may be protected by federal and or state law. If the records are so protected, Federal Regulation (42 CFR part 2) prohibits you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains, or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information for criminal investigations or prosecutions.