AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Patient Information: I give permission to release the health information of: **(One Patient Per Form)**

Patient Name: _____ Date of Birth: _____

Street Address: _____ City, State, Zip: _____

Telephone: ( ) _____ Email Address: _____

By providing your email address you acknowledge and accept the risks outlined in the Guidelines for Electronic Communications posted on atriumhealth.org.

Release Information From:

_____
(List applicable Facility(s) and/or Practice(s)

_____

_____
(Phone number) (Fax number)

Release Information To:

Records Deposition Service
(Name of facility, person, company) (Relationship)

PO Box 5054 Southfield, MI 48086-5054
(Street Address or PO Box, City, State, Zip Code)

(248) 357-3330 E: requests@recdep.com (248) 357-3337
(Phone number) (Fax number)

PURPOSE OF RELEASE (check reason): ☐ Request of individual/personal rep ☐ Continued patient care ☐ Insurance
☒ Legal purpose including discussions & proceedings ☐ Other _____

Fill in dates of treatment for records to be released:
Treatment dates: From _____ **To** _____

Medical Records (check all that may apply):

- ☐ Facility Summary (includes items in **bold**)
- ☐ **Discharge Summary**
- ☐ **History and Physical**
- ☐ **Consultation Reports**
- ☐ **Office/Home Visits**
- ☐ **Emergency Record**
- ☐ **Operative Reports**
- ☐ **Laboratory Reports**
- ☐ **Pathology Reports**
- ☐ **Radiology/X-Ray Reports**
- ☐ **Immunizations**
- ☐ Therapy Notes (Occupational/Physical/Speech)
- ☐ Sleep Study Reports
- ☐ Entire Medical Record (Does not include billing or imaging)
- ☐ Other: _____

Imaging (requires CD format):

- ☐ Radiology Images
- ☐ Cardiology Images (Echo, Cath Lab)
- ☐ Neurology Images (EEG)
- ☐ OBGYN Ultrasound
- ☐ Other Imaging: _____

Billing:

- ☐ Itemized Bill(s)
- ☐ UB04 Form
- ☐ CMS 1500 Form
- ☐ Other Billing: _____

FORMAT:

- ☐ CD (charges may apply)
- ☒ Email Address noted above, where permitted
- ☐ Paper copy (charges may apply)
- ☐ Other _____

DELIVERY METHOD:

- ☐ Reg.US Mail ☐ Fax, where permitted
- ☐ Pick-up, at the following facility: _____
- ☒ Secure email
- ☐ Other: _____

PATIENT'S RIGHTS – I understand that:

- I can cancel this permission at any time. I must cancel in writing and send or deliver cancellation to releasing facility or practice named above. Any cancellation will apply only to information not yet released by facility or practice.
- This is a full release including information related to behavioral/mental health, drug and alcohol abuse treatment (in compliance with 42 CFR Part 2), genetic information, HIV/AIDS, and other sexually transmitted diseases.
- Once my health information is released, the recipient may disclose or share my information with others and my information may no longer be protected by federal and state privacy protections. Records protected by 42 CFR Part 2 may not be redisclosed without my additional consent
- Refusing to sign this form will not prevent my ability to get treatment, payment, enrollment in health plan, or eligibility for benefits.
- Atrium Health will not share or use my health information without my permission other than by ways listed in the Notice of Privacy Practices or as required by law. The Notice of Privacy Practices is available at atriumhealth.org.
- I have a right to a copy of this Authorization.

This permission expires one year after the date of my signature unless another date or event is written here: _____

Signature: _____ **Print Name:** _____ **Date:** _____

Note: If the patient lacks legal capacity or is unable to sign, an authorized personal representative may sign this form.
Note the relationship/authority if signature is not that of the patient (Written proof MAY be requested):

☐ Healthcare Agent/POA ☐ Guardian ☐ Executor/Administrator/Attorney in Fact ☐ Spouse
☐ Parent ☐ Adult Child ☐ Affidavit Next of Kin ☐ Other: _____

Note: If minor consented to a licensed physician for their treatment for pregnancy, sexually transmitted disease, outpatient behavioral/mental health, or outpatient treatment of controlled substances or alcohol without parental consent, the minor must sign this authorization. When the patient is a minor being treated for a substance use disorder and the parent or guardian consented for such treatment, both the minor and parent or guardian must sign this authorization.

Signature of Minor: _____ **Print Name:** _____ **Date:** _____

Date of release: _____ via ☐Mail ☐Fax ☐Other _____ ☐ID Verified ☐DL/Other ID _____
Atrium Health Teammate Name & Department. : _____ **Date:** _____ **# of Pages** _____

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Atrium Health

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Place Patient Label Here