centria HEALTHCARE centria AUTISM life skills AUTISM ACADEMY

Authorization to Disclose Protected Health Information

Client Name: _____ Date of Birth: _____
(First) (Middle) (Last) (MM/DD/YYYY)

Client Address: _____
Street City, State, Zip

I hereby authorize **Centria Healthcare, LLC**, 27777 Inkster Rd., Suite 100, Farmington Hills, Michigan, 48334 (Fax # 248-462-7729), to release information contained in my medical records to:

RECORDS DEPOSITION SERVICE, INC. _____
Recipient's Name Recipient's Title or Relationship to Client

PO BOX 5054 **SOUTHFIELD, MI 48086-5054** **P: 248.357.3330**
Recipient's Address Street City, State, Zip Phone & Fax #

1. Specify type of information to be disclosed:

☐ Demographic Information ☐ Clinical Assessments/Diagnosis ☐ Service Notes

☐ Admission/Intake Documents ☐ Discharge Summary ☐ Financial/Billing Information

☐ Other (Specify) _____ ☐ Entire Medical Record

2. Date(s) of information to be disclosed: From: _____ through _____
(MM/DD/YYYY) (MM/DD/YYYY)

3. The purpose and need for such disclosure is:

☐ Continuation/Coordination of Health Care Treatment ☐ Payment of Health Care Claims

☒ Legal Proceeding ☐ Other (Specify) _____

4. Information is to be: ☐ Mailed ☐ Fax to _____ ☒ Other **UPLOAD TO: WWW.RECDEP.COM**

Your protected health information will be disclosed as specified in this authorization. Information could be subject to re-disclosure by the recipient and may then no longer be protected.

I understand that I have a right to withdraw this authorization at any time. I understand that if I withdraw this authorization, I must do so in writing and present my written statement withdrawing my authorization to the Medical Records Department at Centria. Any revocation will apply only to information not yet released by Centria/LSAA in accordance with the original authorization. Additional information will not be released after the revocation is received.

We will not condition treatment or payment based on this authorization or withdrawal of authorization unless otherwise directed or allowed by law.

This authorization will be valid from the date of your signature until the requested disclosure(s) has been fully completed. This authorization will automatically expire upon the client's termination of services with the company.

_____ _____
Signature of Client **or** Parent/Guardian of Minor (Authorized Representative) Date (MM/DD/YYYY)

_____ _____
Signature/Title or Centria/LSAA Representative **or** Witness to Authorized Signature Date (MM/DD/YYYY)