EMS Division, Detroit Fire Department
Authorization to Use and Disclose Specific Protected Health Information (Legal Representative)

I _____ As the legally authorized representative or guardian
(PRINT THE FULL LEGAL NAME OF THE REPRESENTATIVE OR GUARDIAN)

of: _____ _____ do hereby direct the use or disclosure
(PRINT THE FULL LEGAL NAME OF THE PATIENT) (DATE OF BIRTH)

by the EMS Division of certain medical information pertaining to the health and/or health care, of the patient I have listed above. **(Attach a copy of the "Letters of Authority" or "Guardianship".)**

This authorization concerns the following medical information about the patient listed above:

_____
(PRINT ALL DATE(S) OF SERVICE AND DESCRIPTION OF INFORMATION REQUESTED)

The information may be disclosed by EMS Division to and used by:

RECORDS DEPOSITION SERVICE, INC. , PO BOX 5054, SOUTHFIELD, MI, 48086-5054, P: (248)-357-3330
(LIST THE NAME OR SPECIFIC IDENTIFICATION OF THE PERSON(S) OR CLASS OF PERSONS TO WHOM YOU WANT EMS TO MAKE THE REQUESTED USE/DISCLOSURE)

I understand that I have the right to revoke this Authorization at any time except to the extent that EMS Division has already acted in reliance on the Authorization. To revoke this Authorization, I understand that I must do so by written request to: EMS Division Privacy Officer, 1301 3rd St, 6th floor, Detroit MI 48226. Telephone: (313) 596-5176.

I understand that information used or disclosed pursuant to this Authorization may be subject to redisclosure by the recipient and no longer subject to privacy protections provided by law.

I understand that my written authorization is not required for EMS Division to use the protected health information for treatment, payment, and health care operations.

I understand that I have the right to inspect and copy the information that is to be used or disclosed as part of this Authorizations. The Authorization is being requested from the EMS Division for the following purpose(s):

☐ At my request
☑ Other purpose. Please State: PRE-TRIAL DISCOVERY

I understand that the EMS Division will no condition its treatment on whether I sign this Authorization. I acknowledge that I have ready the provisions in the Authorization. I understand and agree to its terms and acknowledge that I have received a copy of this authorization.

_____ _____
(SIGNATURE OF LEGALLY AUTHORIZED REPRESENTATIVE OR GUARDIAN) (DATE)

_____ _____
(PRINT THE NAME OF THE REPRESENTATIVE OR GUARDIAN) * (DESCRIPTION OF YOUR "LEGAL AUTHORITY OR GUARDIANSHIP)

*If patient is a minor, describe the legal relationship of the minor with the person signing the Authorization. If personal representative or legal guardian, attach a copy of the "Letters of Authority" or "Guardianship".

This authorization expires on initial fulfillment of this request; unless another date or event is specifically stated.
(Date or event)_____
Subscribed and sworn to before me on this _____ day of _____, 20____.

_____
Notary Public
County of _____

My commission expires on: _____

An incomplete form cannot be processed and will be returned in its entirety to the sender.