Fenton Medical Center
Authorization to Use or Disclose Protected Health Information

I, _____Chart # _____Date of Birth_____
authorize Fenton Medical Center, P.C., its employees, agents or records department to release information containing my medical history and demographics (ie name, address, phone and insurance) to the individual (s) or entities listed below:

1. Name of person (s) or individual (s) or entities to whom disclosure is to be made:

RECORDS DEPOSITION SERVICE, INC
PO BOX 5054
SOUTHFIELD, MI 48086-5054
P: 248-357-3330 F: 248-357-3337

2. Records are being sent for the purpose of: (chose one)
[ ] Transferring out of clinic [ ] Disability Purposes [ ] Life / Health Insurance
[ ] Referral to Specialist [ ] Workers Comp [ ] Auto Accident Related
[XX] Other (please specify) DISCOVERY.

3. Specific dates of records to be released from : (chose one)
[ ] specific dates_____to _____ [ ] entire medical record

This authorization permits Fenton Medical Center to disclose ONLY the information determined to be the minimum necessary (unless "entire medical record" option is selected above) to the person's indicated above. Additional information shall require another authorization.

4. Specific type of information to be disclosed subject to the provisions of 1978 Michigan P.A. 368, as amended, and the Veterans Benefits and Services Act of 1988 P.L. 100-32: Medical, Psychiatric, Psychological, Vocational records of evaluation and / or treatment for physical and / or emotional illness including past history, diagnosis, complications, and sequelae, prognosis, progress notes, medication, workshop evaluations, training reports, referring physician report, insurance reports, IQ scores, treatment plans, recommendations, summaries, current status, evaluation and treatment records of alcohol or drug abuse, sickle cell anemia, any information regarding communicable diseases , serious communicable diseases and infections which include venereal diseases, tuberculosis, hepatitis B, HIV infection, AIDS or ARC.

5. Any information specifically requested not to be released from record: _____

_____

_____

6. This consent may be revoked at any time. It shall be valid for no longer than 30 days from the signature date which is reasonably necessary to accomplish the purpose for which it was given. I understand that the records release for the above will be treated confidentially. I understand I have the right to revoke this authorization in writing except to the extent that action has been taken in reliance of this authorization or, if applicable, during a contestability period. In order for the revocation of this authorization to be effective, Fenton Medical Center must receive the revocation in writing. The revocation must include:

- The patient's name and address.
- The effective date of this authorization and the recipients of the protected health information according to this authorization.
- The patient's desire to revoke this authorization, and

- The date of the revocation, and the patient's signature.

Fenton Medical Center will accept written revocations of this authorization by Certified U.S. Mail or Facsimile to this number 810-629-6535.

All revocations must be sent to Fenton Medical Center to the attention of Kaye or Penny, and are not effective until received.

I, _____ understand Fenton Medical Center is authorized by me to use or disclose my protected health information for a purpose other than treatment, payment or health care operations. I have read this authorization and understand what information will be used or disclosed, who may use and disclose the information, and the recipient(s) of that information. I specifically authorize any current employee or owner of Fenton Medical Center to disclose my protected health information as described on this form to the recipients listed above. I certify that the information on this request form is true and accurate to the best of my knowledge.

Patient Signature_____Date_____
(If minor, parent or guardian must sign)

This release must always be signed by a witness.
Two witness are required if the statement has been signed by an "X"

Witnessed by: _____Date_____Relationship_____

Witnessed by: _____Date_____Relationship_____

FOR OFFICE USE ONLY

Verified authority to request information using:
[ ] Patient's current authorization [ ] Judicial subpoena/court document

Number of patient records included in this request: _____.

Request entered into log book on _____at page _____.

[ ] Request approved by _____ on _____.

[ ] Information sent to recipient via _____ on _____.