THIS FORM MUST BE COMPLETED IN THE ENTIRETY BY THE PATIENT OR THE PATIENT'S LEGAL GUARDIAN

TRIHEALTH G, LLC d.b.a. GROUP HEALTH ASSOCIATES
AUTHORIZATION FOR USE OR DISCLOSURE
OF PROTECTED HEALTH INFORMATION

Patient Name *(please print)*		Maiden Name
Social Security Number	Date of Birth	Phone Number
Address		

1. I authorize _____
NAME

_____
STREET ADDRESS

_____
CITY, STATE AND ZIP CODE

(insert name of hospital /health care facility/physician office] (referred to as "Health Care Provider") to use and/or disclose my/the patient's individually identifiable health information as described below.

2. I authorize the following person(s) or organization to receive the information:
RECORDS DEPOSITION SERVICE, INC.
NAME
P.O. BOX 5054
STREET ADDRESS
SOUTHFIELD, MI 48086-5054 P: 248-357-3330 F: 248-357-3337
CITY, STATE AND ZIP CODE

3. **Type of Information to be Released:** Check the type of information that you want to be used or disclosed pursuant to this Authorization—

A. **Medical Records:** ***CHECK ONE***
☐ **All medical records; *or***
☑ **I only want the parts of my medical record described below to be disclosed:**
PLEASE SEE THE ATTACHED SUBPOENA OR LETTER REQUEST

B. **Billing Records:**
☑ **All billing records including itemized statements**

C. **Dates of Treatment:** ***CHECK ONE***
☐ **All dates of treatment; *or***
☑ **I only want records for the following dates of treatment to be disclosed:**
PLEASE SEE THE ATTACHED SUBPOENA OR LETTER REQUEST

I authorize the release of any information contained in the above records concerning treatment of drug or alcohol abuse, drug-related conditions, alcoholism and/or Acquired Immune Deficiency Syndrome (AIDS) and/or testing for antibodies to the AIDS virus (HIV) and/or psychiatric/psychological conditions and/or psychiatric/mental health treatment.

2-sided document

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Please check the reason for the use and/or disclosure of the information:

☑ Lawsuit/legal preparation ☐ At patient's request ☐ Applying for Disability

☐ Applying for insurance ☐ Other:_____

Your Refusal to Sign this Authorization: The Health Care Provider may not condition treatment, payment, enrollment in a health plan or eligibility for benefits, on whether or not you sign this Authorization. If you refuse to sign this Authorization the Health Care Provider will not withhold treatment from you and will not release the information to the person or organization specified above.

Re-disclosure: I understand that the information used and/or disclosed pursuant to this Authorization may be re-disclosed by the recipient of the information and may no longer be protected by Federal law. However, if the information disclosed pursuant to this Authorization includes alcohol or drug treatment records, the person(s) receiving such disclosure is hereby notified that this information has been disclosed from records protected by Federal confidentiality rules (42 CFR part 2). The Federal rules prohibit such person(s) from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the patient 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 to criminally investigate or prosecute any alcohol or drug abuse patient. If the information disclosed pursuant to this Authorization includes the identity of an individual on whom an HIV test is performed, HIV test results or AIDS-related treatment information, the person(s) receiving such disclosure is hereby notified that this information has been disclosed from confidential records protected from disclosure by Ohio law. Ohio law prohibits such person(s) from making any further disclosure of this information without the specific, written, and informed release of the patient to whom it pertains, or as otherwise permitted by Ohio law. A general authorization for the release of medical or other information is not sufficient for the purpose of the release of HIV test results or diagnoses.

Expiration: This Authorization will expire one year after the date below, or sooner by choice, in which case this Authorization will expire on _____. However, if the records to be used or disclosed pursuant to this Authorization concern psychiatric, psychological and/or mental health treatment, this Authorization will expire 90 days after the date below, or sooner by choice, in which case this Authorization will expire on _____ (If applicable, insert date on the foregoing line. Note: You may not indicate that there is no expiration; for example, the words "does not expire" or "no expiration" or "none" are not acceptable).

Revocation: I understand that I may revoke this Authorization at any time by notifying the Health Care Provider in writing by sending a letter to the attention of the Manager of the Health Information Management Department/Medical Records Department at the Health Care Provider's mailing address. I understand that if I revoke this Authorization, it will not affect any actions that Health Care Provider took before it received my revocation letter.

_____ _____

SIGNATURE OF PATIENT OR PATIENT'S REPRESENTATIVE **DATE**

Printed name of patient's representative, if applicable: _____

Relationship to patient (check box):

☐ Parent ☐ Legal Guardian ☐ Other:_____

*Legal documentation of Representative's authority must accompany this Authorization.

Amount paid $_____, by ☐ Check ☐ Cash ☐ Credit Card

Payment received by: _____

Please note that there may be a charge to copy records that are not being sent to a physician or health care facility for further medical care. The health care provider may use a copy service and it may bill you directly.