Authorization for Disclosure of Health Information

(1) I hereby authorize ____Highmark Blue Shield_____ to release/disclose the
[Name of Releaser-e.g., Highmark Blue Shield or other entity.]

following information of :

_____ _____
Patient/Member Name Date of Birth

_____

_____

_____
Address

_____ _____
Identification Number Telephone

The records to be disclosed cover the following period(s):

_____ _____
From (date) To (date)

_____ _____
From (date) To (date)

(2) ☐ Check if this information is for psychotherapy notes

<If this authorization is for psychotherapy notes, you must ***not*** use it as an authorization for any other type of protected health information.>

(3) Information to be disclosed. (Please check only that which applies.)

Designated Record Set: (Please check only that which applies.)

☐Enrollment Information ☐Claims Information ☐Payment Information

☐ Managed Care Information (Precertification, 2nd Opinions, Treatment Plans, Care Coordination, Case Management etc.)

AND/OR

☐ Pharmaceutical Information ☐ Discharge summary ☐ History and physical examination

☐ Consultation reports ☐ Progress notes ☐ Laboratory tests

☐ X-Ray Reports ☐ Explanation of Benefits ☐ Complete Health Record(s)

☐ Other (please specify) _____

I understand that this will include information relating to (check if applicable):

☐ Acquired Immunodeficiency Syndrome (AIDS) or infection with HIV (Human Immunodeficiency Virus)

☐ Mental healthcare ☐ Sexually transmitted Disease ☐ Treatment for alcohol and/or drug abuse

☐Other (please specify) _____

(4) This information is to be disclosed to **RECORDS DEPOSITION SERVICE, INC.**
PO BOX 5054
SOUTHFIELD, MI 48086-5054

P: 248.357.3330 F: 248.357.3337

by Releaser for the purpose of

FOR DISCOVERY BEFORE TRIAL

[state purpose]

(5) I understand that I may revoke this authorization at any time by giving written notice of my revocation to

Highmark Blue Shield

I understand that revocation of this authorization will *not* affect any action Releaser took in reliance on this authorization before it received my written notice of revocation. I also understand that without my written authorization, Releaser may not use or disclose my health information for any reason except those described in Releaser's Notice of Privacy Policies and Practices. Unless otherwise revoked, this authorization will expire on the following date, event or circumstance:
[insert date, event, or circumstance-if no date, event or circumstance is included, this Authorization will expire on year after date of member signature]

I understand that authorizing the disclosure of this health information is voluntary, and that I can refuse to sign this authorization.

I understand that, if the persons or organization I authorize to receive and/or use the protected health information described above are not health plans, covered health care providers or health care clearinghouses subject to federal health information privacy laws, they may further disclose the protected health information and it may no longer be protected by federal health information privacy laws.

I understand that Releaser may condition my enrollment or eligibility for benefits on my signing of this authorization (other that for psychotherapy notes), before Releaser enrolls me, to allow Releaser to obtain protected health information from another covered entity to determine my eligibility or enrollment or Releaser's underwriting or risk rating.

I understand that Releaser may condition payment of a claim for specified benefits on my signing of this authorization (other than for psychotherapy notes) to allow other covered entities to disclose protected health information to Releaser that Releaser needs to determine payment of my claim.

Releaser, its subsidiaries, affiliates, employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosed of the above information to the extent indicated and authorized.

Signed (Patient/Member) Date

(Personal Representative) (Include a description of such representative's authority to act for the patient/member) Date

You are entitled to a copy of this authorization after you sign it.