McLaren

MACOMB

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION (P.H.I.)

Patient's Name: _____

(Maiden): _____ Birthdate: _____

Patient's Address: _____ Social Security #: _____

_____ Telephone #: _____

1. Receiver of Information:

Name: **RECORDS DEPOSITION SERVICE, INC.**

Address: **PO BOX 5054**

City / State: **SOUTHFIELD, MI**

Zip: **48086-5054**

2. Specific information to be disclosed and date(s) of service or date range: _____

Please see enclosed Subpoena or Letter Request for information to be disclosed.

3. Reason for the information: (check one below)

☐ Personal ☐ Insurance ☐ Attorney ☐ Continuity of Care

☒ Other: **For Discovery Before Trial**

4. I authorize McLAREN MACOMB MEDICAL CENTER (OR SPECIFY)_____ to release all requested information contained in my medical record including as applicable:

A. Information about serious communicable diseases and infections, as defined by statue and Michigan Department of Public Health rules (which include HUMAN IMMUNODEFICIENCY VIRUS "AIDS," acquired immunodeficiency syndrome AIDS, and AIDS related complex "ARC") and specify other, if known.

B. Alcohol and drug abuse treatment information protected under the regulations in 42 code of Federal regulations.

C. Mental health treatment records, psychological services and social services information including communications made by me to a Social Worker or Psychologist only as specified above.

D. This authorization is in effect for no more than 60 days after date it was signed unless otherwise specified. Upon conclusion of that time period, this authorization is automatically revoked and no further disclosure of the patient's confidential healthcare information is permitted beyond that date. The patient reserves the right to revoke this authorization at any time, any revocation must be in writing.

E. If Legal Guardian or Personal Representative, a copy of appropriate documentation is necessary for release.

F. Treatment, payment or eligibility for benefits will not be conditioned upon signing of this authorization.

G. I understand that my health information disclosed under this Authorization may be subject to re-disclosure by the recipient.

H. I understand that if I am authorizing the release of protected health information not created by MMCM, that MMCM cannot verify the accuracy or completeness of records created by other providers.

I. I understand that Michigan law allows MMCM to charge a reasonable fee for the requested copies from the medical record.

_____ _____

Witness Signature

Drivers License (last 4 digits) _____

_____ Patient _____

Date Legal Guardian _____

Parient _____

Other Authorized Rep. _____

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