RECORDS DEPOSITION SERVICE®
I N C O R P O R A T E D

P.O. BOX 5054
SOUTHFIELD, MICHIGAN 48086-5054
PHONE: (248) 357-3330 TELECOPIER: (248) 357-3337

MEDICAL AUTHORIZATION

I, ____,
(PATIENT NAME)

HEREBY AUTHORIZE
WISCONSIN PHYSICIAN SERVICES/HEALTH CARE FINANCING ADMINISTRATION
(HOSPITAL/DOCTOR NAME)

IT'S DIRECTOR OR DESIGNEE, OR MEDICAL RECORD DEPARTMENT, TO RELEASE INFORMATION CONTAINED IN MY PATIENT RECORDS, INCLUDING ALCOHOL AND DRUG ABUSE RECORDS PROTECTED UNDER THE REGULATIONS IN CODE 42 OF FEDERAL REGULATIONS, PART2, IF ANY; PSYCHOLOGICAL SERVICES RECORDS, IF ANY; SOCIAL SERVICES RECORDS, IF ANY; PSYCHIATRIC RECORDS, IF ANY; INCLUDING COMMUNICATIONS MADE BY ME TO A SOCIAL WORKER, PSYCHOLOGIST OR PSYCHIATRIST, HUMAN IMMUNODEFICIENCY VIRUS (HIV), ACQUIRED IMMUNODEFICIENCY SYNDROME (AIDS), AND AIDS RELATED COMPLEX (ARC) RECORDS, IF ANY; COMMUNICABLE DISEASE AND SERIOUS COMMUNICABLE DISEASE AND INFECTIONS, VENEREAL DISEASES, TUBERCULOSIS, HEPATITIS B RECORDS, SICKLE CELL ANEMIA RECORDS, IF ANY; TO THE INDIVIDUALS OR ORGANIZATIONS LISTED BELOW, ONLY UNDER THE CONDITIONS BELOW.

BIRTHDATE OF PATIENT: ____________________ SOCIAL SECURITY NUMBER: ____________________

1. TO WHOM DISCLOSURE IS TO BE MADE: *RECORDS DEPOSITION SERVICE, INCORPORATED*
   27355 W. ELEVEN MILE ROAD
   P.O. BOX 5054
   SOUTHFIELD, MI 48086-5054

   NOTE: DISCLOSURE IS TO BE MADE TO R.D.S., INC. ONLY. ALL OTHER DISCLOSURES ARE UNAUTHORIZED.

2. INFORMATION TO BE DISCLOSED: BILLING, PAYMENT RECORDS AND SERVICES RENDERED BY ALL HEALTH CARE PROVIDERS, MEDICARE PART B

3. THE PURPOSE AND NEED FOR SUCH DISCLOSURE: FOR PRE-TRIAL DISCOVERY

4. THIS AUTHORIZATION IS SUBJECT TO REVOCATION AT ANY TIME BY CONTACTING R.D.S., INC. IN WRITING. I UNDERSTAND THAT THE REVOCATION WILL NOT APPLY TO INFORMATION THAT HAS ALREADY BEEN RELEASED IN RESPONSE TO THIS AUTHORIZATION.

5. WITHOUT EXPRESSED REVOCATION, THIS AUTHORIZATION EXPIRES ON THE DATE SET FORTH: ______________ OR THE FOLLOWING EVENT: ONCE INFORMATION IS DISCLOSED, NO FURTHER INFORMATION CAN BE DISCLOSED PURSUANT TO THIS AUTHORIZATION.

6. I UNDERSTAND THE PROVIDER MAY NOT CONDITION TREATMENT, PAYMENT, ENROLLMENT OR ELIGIBILITY FOR BENEFITS ON WHETHER I SIGN THIS FORM.

7. A PHOTOCOPY OF THIS DOCUMENT SHALL BE CONSIDERED VALID AS IF THE ORIGINAL WERE OFFERED. THIS AUTHORIZATION IS ONLY VALID IF SUBMITTED BY R.D.S.,INC. I UNDERSTAND THAT INFORMATION USED OR DISCLOSED PURSUANT TO THIS AUTHORIZATION MAY BE SUBJECT TO RE-DISCLOSURE BY THE RECIPIENT AND MAY NO LONGER BE PROTECTED BY FEDERAL OR STATE LAW. R.D.S., INC IS NOT LIABLE FOR DAMAGES AS THE RESULT OF AN UNAUTHORIZED DISCLOSURE.

X____________________ X____
DATE SIGNED SIGNATURE OF PATIENT

X____________________ X____
DATE SIGNED SIGNATURE OF PARENT/GUARDIAN/PERSONAL REPRESENTATIVE WITH RELATIONSHIP TO PATIENT

SUBSCRIBED AND SWORN BEFORE ME, THIS ______________ DAY OF ____________________. 20______.

______________________________, NOTARY PUBLIC ______________________ COUNTY;

MY COMMISSION EXPIRES: ____________

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