Northeast Surgical Group, P.C.

Authorization for Use or Disclosure of Protected Health Information

*(This form must be filled out completely on both pages…**PLEASE PRINT**)*

I, ______________________________, _______________ hereby authorize Northeast Surgical Group, P.C.
Patient's LEGAL Name — Date of Birth

to use or disclose the following protected health information (PHI): ***(Specifically describe the information to be used or disclosed, including, but not limited to, meaningful descriptors such as date of service, type of service provided, level of detail to be released, origin of information, etc. If applicable, explicitly state that the protected health information is pertaining to alcohol abuse, substance abuse, psychotherapy notes, psychiatric services, social services, HIV, AIDS, and/or ARC.)***

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The protected health information may be disclosed to:

NAME OF PERSON / ENTITY: RECORDS DEPOSITION SERVICE, INC.

ADDRESS: PO BOX 5054, SOUTHFIELD, MI 48086-5054

PHONE # (_______) 248.357.3330 FAX # (_______) 248.357.3337

(Insert name of person, or entity, or insert specific identification of class of persons, who may receive the information…AND THEIR COMPLETE MAILING ADDRESS AND/OR PHONE/FAX NUMBERS)

This protected health information is being used or disclosed for the following purposes: (*Specifically list all applicable purposes here.* ***The patient may indicate that the use or disclosure is "at the request of the individual patient" if the patient initiates the authorization and does not choose to provide an explanation of the purpose of the request)***

FOR DISCOVERY BEFORE TRIAL

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This authorization shall be in force and effect until: ***(check AND complete one of the following)***

- ☐ **The expiration date, which is:** ______________________________
- ☐ **The occurrence of following expiration event, which relates to the patient or the purpose of the use or disclosure:** ______________________________

I understand that, as set forth in Northeast Surgical Group, P.C. Notice of Privacy Practices, I have the right to revoke this authorization, in writing, at any time by sending written notification to the Privacy Official at:

Northeast Surgical Group, P.C.
17375 Hall Road
Macomb Township, Michigan 48044

I understand that a revocation is not effective to the extent that Northeast Surgical Group, P.C. has relied on such authorization.

I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act of 1996 Privacy Rule.

Authorization for Use or Disclosure of Protected Health Information
(This form must be filled out completely on both pages)

Check only One of the following Boxes:

❑ A. If Northeast Surgical Group, P.C. has initiated this Authorization for Use or Disclosure of Protected Health Information for Non-TPO (Treatment, Payment, Health Care Operations) purposes, I understand that Northeast Surgical Group, P.C. may not condition my treatment on whether I provide authorization for the requested use or disclosure.

❑ **B. I understand that the release of my protected health information (which may include medical records and/or billing records) *by* Northeast Surgical Group, P.C. is only for the purpose of providing protected health information for disclosure to a third party,**

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Name of Individual, Entity or Class of Persons
and that my authorization for the disclosure of my protected health information to such third party is a condition of treatment or health care services by the third party. I understand that if I do not sign this authorization, then Northeast Surgical Group, P.C. will not release protected health information to the third party.

❑ C. I understand that the treatment being provided by Northeast Surgical Group, P.C. is related to research and that my authorization for the use or disclosure of the protected health information for such research is a condition of this treatment. I understand that if I do not sign this authorization, then Northeast Surgical Group, P.C. will not provide research related treatment to me.

Check this Box if applicable:

❑ I understand that Northeast Surgical Group, P.C. will receive direct or indirect remuneration from a third party for the use or disclosure of protected health information for marketing.

I understand that I have the right to refuse to sign this authorization.

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PRINTED LEGAL Name of Patient or Personal Representative and Description of Authority

____________________________ ________________________
Patient Date of Birth **Patient Social Security Number**

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Patient Address

____________________________ ____________________
***Signature* of Patient or Personal Representative** **Date**

____________________________ ____________________
***Signature* of Witness *THIS IS REQUIRED** **Date**

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FOR OFFICE USE ONLY

I am the Custodian of Protected Medical Information for Northeast Surgical Group, P.C.

☐ I have examined the original patient health information (PHI) record and released a true and complete copy of the requested information as described in the authorization.

☐ A total of ______pages were copied and released as authorized on this date. I declare that the above statements are true to the best of my knowledge.

❑ **A COPY OF THIS SIGNED AUTHORIZATION WAS PROVIDED TO THE PATIENT and/or to the person/entity receiving the disclosed information.**

❑ **If mailed, a copy of the stamped, addressed envelope/box was retained as proof of mailing.**

Printed Name ____

Signature ____________________________ **Date** ________________