

Client Authorization Forms

Α

Operation PAR, Inc.

P.O. BOX 5054, SOUTHFIELD, MI 48086-5054 P. 248-357-3330 F: 248-357-3337 F: 248-257-257 F: 248-257-25	Medical Records Department - 6	720 54th Avenue North · St. Pet	ersburg · FL 33709	- Phone: 727-545-7544
uthorize Operation PAR, Inc., to disclose to: (Provide Name and Address) RECORDS DEPOSITION SERVICE, INC. P. O. BOX 5054, SOUTHFIELD, MI 48086-5054 P: 248-357-3330 F: 248-357-3337 P: 248-357-3330 F: 248-357-3337 P: 248-357-3330 F: 248-357-3337 P: 248-357-3337 F: 248-357-3337 P: 248-357-3337 F: 248-357-3337 P: 248-357-3337 F: 248-357-3337 P: 248-357-3337 F: 248-357-3337 Respectively.	AUTHORIZATION FOR DIS	SCLOSURE OF CONFIDENT	IAL INFORMATIO	N - GENERAL
Authorize Operation PAR, Inc., to disclose to: (Provide Name and Address) (Provide Name and Address) P. 248-357-3330 P. 248-357-3337 P. 248-357-337 P. 248-357-3		, DOB:	SS#	PH#
(Provide Name and Address) P.O. BOX 5054, SOUTHFIELD, MI 48086-5054 P: 248-357-3330 F: 248-357-3320 F: 248-357-3320 F: 248-357-3320 F: 248-357-3320 F: 248-3	(Client Name)			
P.O. BOX 5054, SOUTHFIELD, MI 48086-5054 P: 248-357-3330 F: 248-357-3337 P: 248-357-3337 P: 248-357-3330 F: 248-357-3337 P: 248-357-34 P: 248-357-3337 P: 248-357-34 P: 248-357-3337 P: 248-357-34 P: 248-357-34 P: 248-357-34	Authorize Operation PAR, Inc., to disclose to: (Provide Name and Address)	RECORDS DEPOSITION SERVICE, INC.		
he following information: Note: Draw a line through information not needed. ssessments, History and Physical, Medication Administration Records, Treatment Plan, Progress Notes, Lab Results, ischarge Summary and Continuing Care Plan, Other PLEASE SEE ATTACHED SUBPOENA OR LETTER REQUEST FOR INFORMATION TO BE DISCLOSED urpose for the disclosure—be specific: FOR DISCOVERY BEFORE TRIAL. prional: I also agree to the disclosure of HIV Testing information and AIDS Diagnosis: Client Initials information will be disclosed in writing and/or verbally. Client initial for FAX approval: understand that my records are protected under the Federal and State regulations governing the confidentiality and privacy of nedical records and protected alcohol and drug abuse health information under 42 C.F.R., Part 2, and the Health Insurance ortability and Accountability Act of 1996 ("HIPAA") 45 C.F.R., Parts 160 and 164 and cannot be disclosed without my written uthorization unless otherwise provided for by the regulations. also understand that I may revoke this authorization in writing at any time except to the extent that action has already been taken elalance on it, and that in any event this authorization expires automatically after one year, unless otherwise stated below: ate, event or condition of expiration: understand that I might be denied services if I refuse to consent to a disclosure for treatment, payment or healthcare operations, ermitted by state law. I will not be denied services if I refuse to consent to disclosure for other purposes. I also hereby release peration PAR, Inc., from liability which may arise as a result of information disclosed under an authorization, if such information isclosed is later used to my detriment. Date: Signature: Viewess Date: Signature: Authorized Representative Legal Authority to Act Legal Authority to Act				
ischarge Summary and Continuing Care Plan, Other PLEASE SEE ATTACHED SUBPOENA OR LETTER REQUEST FOR INFORMATION TO BE DISCLOSED urpose for the disclosure-be specific: FOR DISCOVERY BEFORE TRIAL potional: I also agree to the disclosure of HIV Testing information and AIDS Diagnosis: Client initial information will be disclosed in writing and/or verbally. Client initial for FAX approval: understand that my records are protected under the Federal and State regulations governing the confidentiality and privacy of neclical records and protected alcohol and drug abuse health information under 42 C.F.R., Part 2, and the Health Insurance ortability and Accountability Act of 1996 ("HIPAA") 45 C.F.R., Parts 160 and 164 and cannot be disclosed without my written uthorization unless otherwise provided for by the regulations. also understand that I may revoke this authorization in writing at any time except to the extent that action has already been taken eliance on it, and that in any event this authorization expires automatically after one year, unless otherwise stated below: ate, event or condition of expiration: understand that I might be denied services if I refuse to consent to a disclosure for treatment, payment or healthcare operations, ermitted by state law. I will not be denied services if I refuse to consent to disclosure for other purposes. I also hereby release peration PAR, Inc., from liability which may arise as a result of information disclosed under an authorization, if such information isclosed is later used to my detriment. Date: Signature: Cent Signature: Authorized Representative Legal Authority to Act Date released.	he following information: Note: Draw a lin	ne through information <u>not</u> needed		8-357-3330 F: 248-357-3337
University of the disclosure be specific: FOR DISCOVERY BEFORE TRIAL potional: I also agree to the disclosure of HIV Testing information and AIDS Diagnosis: Client Initial potional: I also agree to the disclosure of HIV Testing information and AIDS Diagnosis: Client Initial for FAX approval: understand that my records are protected under the Federal and State regulations governing the confidentiality and privacy of nedical records and protected alcohol and drug abuse health information under 42 C.F.R., Part 2, and the Health Insurance ortability and Accountability Act of 1996 ("HIPAA") 45 C.F.R., Parts 160 and 164 and cannot be disclosed without my written uthorization unless otherwise provided for by the regulations. also understand that I may revoke this authorization in writing at any time except to the extent that action has already been taken eliance on it, and that in any event this authorization expires automatically after one year, unless otherwise stated below: ate, event or condition of expiration: understand that I might be denied services if I refuse to consent to a disclosure for treatment, payment or healthcare operations, ermitted by state law. I will not be denied services if I refuse to consent to disclosure for treatment, payment or healthcare operations, ermitted by state law. I will not be denied services if I refuse to consent to disclosure for treatment, payment or healthcare operations, ermitted by state law. I will not be denied services if I refuse to consent to disclosure for treatment, payment or healthcare operations, ermitted by state law. I will not be denied services if I refuse to consent to disclosure for treatment, payment or healthcare operations, ermitted by state law. I will not be denied services if I refuse to consent to disclosure for treatment, payment or healthcare operations, ermitted by state law. I will not be denied services if I refuse to consent to disclosure for treatment, payment or healthcare operations, ermitted by state law. I will not be denied serv	ssessments, History and Physical, Medi	cation Administration Records,	Freatment Plan, F	Progress Notes, Lab Results,
urpose for the disclosure-be specific: FOR DISCOVERY BEFORE TRIAL prional: I also agree to the disclosure of HIV Testing information and AIDS Diagnosis: Citent Initials Information will be disclosed in writing and/or verbally. Client initial for FAX approval: understand that my records are protected under the Federal and State regulations governing the confidentiality and privacy of redical records and protected alcohol and drug abuse health information under 42 C.F.R., Part 2, and the Health Insurance oritability and Accountability Act of 1996 ("HIPAA") 45 C.F.R., Parts 160 and 164 and cannot be disclosed without my written uthorization unless otherwise provided for by the regulations. also understand that I may revoke this authorization in writing at any time except to the extent that action has already been taken eliance on it, and that in any event this authorization expires automatically after one year, unless otherwise stated below: ate, event or condition of expiration: understand that I might be denied services if I refuse to consent to a disclosure for treatment, payment or healthcare operations, ermitted by state law. I will not be denied services if I refuse to consent to disclosure for other purposes. I also hereby release peration PAR, Inc., from liability which may arise as a result of information disclosed under an authorization, if such information is closed is later used to my detriment. Date: Signature: Witness Date: Signature: Authorized Representative Legal Authority to Act Date released: Intermetion released by: Intermetion released.	hischarge Summary and Continuing Care Plan,	Other PLEASE SEE ATTA	CHED SUBPOE	<u>NA</u>
Information will be disclosed in writing and/or verbally. Client initial for FAX approval:	-	RMATION TO BE DISCLOSE	ED	
Information will be disclosed in writing and/or verbally. Client initial for FAX approval: understand that my records are protected under the Federal and State regulations governing the confidentiality and privacy of redical records and protected alcohol and drug abuse health information under 42 C.F.R., Part 2, and the Health insurance ortrability and Accountability Act of 1996 ("HIPAA") 45 C.F.R., Parts 160 and 164 and cannot be disclosed without my written uthorization unless otherwise provided for by the regulations. also understand that I may revoke this authorization in writing at any time except to the extent that action has already been taken eliance on it, and that in any event this authorization expires automatically after one year, unless otherwise stated below: ate, event or condition of expiration: understand that I might be denied services if I refuse to consent to a disclosure for treatment, payment or healthcare operations, ermitted by state law. I will not be denied services if I refuse to consent to disclosure for other purposes. I also hereby release peration PAR, Inc., from liability which may arise as a result of information disclosed under an authorization, if such information isclosed is later used to my detriment. Date: Signature: Client signature Date: Signature: Authorized Representative Legal Authority to Act Date released: Information released:	urpose for the disclosure-be specific:	OR DISCOVERY BEFORE	TRIAL	
understand that my records are protected under the Federal and State regulations governing the confidentiality and privacy of ledical records and protected alcohol and drug abuse health information under 42 C.F.R., Part 2, and the Health Insurance ortability and Accountability Act of 1996 ("HIPAA") 45 C.F.R., Parts 160 and 164 and cannot be disclosed without my written uthorization unless otherwise provided for by the regulations. also understand that I may revoke this authorization in writing at any time except to the extent that action has already been taken eliance on it, and that in any event this authorization expires automatically after one year, unless otherwise stated below: ate, event or condition of expiration: understand that I might be denied services if I refuse to consent to a disclosure for treatment, payment or healthcare operations, ermitted by state law. I will not be denied services if I refuse to consent to disclosure for other purposes. I also hereby release peration PAR, Inc., from liability which may arise as a result of information disclosed under an authorization, if such information is later used to my detriment. Date: Signature: Client Signature Oater Signature: Authorized Representative Legal Authority to Act For Office Use: Authorized information released by: Information released:	optional: I also agree to the disclosure of HIV Te	sting information and AIDS Diagnosis	S:Client Initials	
nedical records and protected alcohol and drug abuse health information under 42 C.F.R., Part 2, and the Health Insurance ortability and Accountability Act of 1996 ("HIPAA") 45 C.F.R., Parts 160 and 164 and cannot be disclosed without my written uthorization unless otherwise provided for by the regulations. also understand that I may revoke this authorization in writing at any time except to the extent that action has already been taken eliance on it, and that in any event this authorization expires automatically after one year, unless otherwise stated below: ate, event or condition of expiration: understand that I might be denied services if I refuse to consent to a disclosure for treatment, payment or healthcare operations, ermitted by state law. I will not be denied services if I refuse to consent to disclosure for other purposes. I also hereby release operation PAR, Inc., from liability which may arise as a result of information disclosed under an authorization, if such information isclosed is later used to my detriment. Date: Signature: Chent Signature Date: Signature: Authorized Representative Legal Authority to Act For Office Use: Authorized information released by: Information released:	nformation will be disclosed in writing and/or v	verbally. Client initial for FAX a	approval:	
understand that I might be denied services if I refuse to consent to a disclosure for treatment, payment or healthcare operations, ermitted by state law. I will not be denied services if I refuse to consent to disclosure for other purposes. I also hereby release peration PAR, Inc., from liability which may arise as a result of information disclosed under an authorization, if such information isclosed is later used to my detriment. Date: Signature: Client Signature Witness Date: Signature: Authorized Representative Legal Authority to Act For Office Use: Authorized information released by: Information released:	also understand that <u>I may revoke this autho</u> eliance on it, and that in any event <u>this autho</u>	rization in writing at any time exce	ept to the extent that or one year, unless o	action has already been taken therwise stated below:
ermitted by state law. I will not be denied services if I refuse to consent to disclosure for other purposes. I also hereby release peration PAR, Inc., from liability which may arise as a result of information disclosed under an authorization, if such information isclosed is later used to my detriment. Date:Signature:	ate, event or condition of expiration:			
Date:Signature:	ermitted by state law. I will not be denied se peration PAR, Inc., from liability which may a isclosed is later used to my detriment.	rvices if I refuse to consent to disc	closure for other pur	poses. I also hereby release
Date: Signature: Authorized Representative Legal Authority to Act For Office Use: Authorized information released by: Date released: Information released:	Date: Signature:	Client Signature		
Date: Signature: Authorized Representative Legal Authority to Act For Office Use: Authorized information released by: Date released: Information released:	Date: Clanation:			
Authorized Representative Legal Authority to Act For Office Use: Authorized information released by: Information released:	Date:Signature:	Witness		
Authorized Representative Legal Authority to Act For Office Use: Authorized information released by: Information released:				
Information released:	Date:Signature:	Authorized Representative		Legal Authority to Act
Information released:				
Information released:				
	For Office Use: Authorized information released by:		D	ate released:
(PAR # 2101A 5-05)	Information released: (PAR # 2101A 5-05)			