Authorization for Release of Resident Medical Record/Protected Health Information

Resident Name: ________________________________

Date of Request: __________________

Senior Living Community Where Resident Resides: ____

Resident Date of Birth: ___________________________

Person Requesting Medical Record: RECORDS DEPOSITION SERVICE, INC.

Relationship to Resident:

_____ Self (Resident)

______Legal Guardian

______Durable Power of Attorney (DPOA)

______Court appointed representative over residents' estate

______Next of kin: (enter relationship) _______________________

For legal compliance reasons, a copy of a fully executed legal document establishing your position as the legal guardian or DPOA must be attached to this Authorization request.

If the Resident is deceased, a fully executed legal document establishing that you are a court-appointed representative (Administrator or Executor) over the Resident's estate must be attached to this Authorization request.

Dates of the Medical Records Being Requested (starting and ending dates):

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Specific Portion(s) of Medical Record Requested:

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Purpose of the Disclosure of Record:

LEGAL DISCOVERY

Release of Medical Record:

______I will pick the medical record up in person.

X_____Mail to the following address: PO BOX 5054, SOUTHFIELD, MI 48086-5054 P: 248.357.3330

Please note that for security reasons, we cannot email records.

I understand that by signing this Authorization:

- I authorize the release of my/the Resident's individually identifiable health information as described above for the purpose listed.
- I can revoke this Authorization at any time, by sending written notification to Provision Living, 9450 Manchester Rd., Suite 207, St. Louis, MO 63119, Attn:
- However, I understand that any actions already taken in reliance on this Authorization cannot be reversed and my revocation will not affect those actions.
- I understand that a person to whom records and information are disclosed pursuant to this Authorization may not further use or disclose the medical information unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law.
- We will provide one free copy of the records. Additional copies can be requested at a per page cost per state/federal regulations.
- I have the right to receive a copy of this Authorization.
- I am signing this Authorization voluntarily and treatment, payment, or eligibility for benefits will not be affected if I do not sign this Authorization.
- This Authorization expires one year from date of request.

____________________________________ ____________________________________

Signature of Resident | Printed Name of Resident

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Date

OR

____________________________________ ____________________________________

Signature of Legal Representative | Printed Name of Legal Representative

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Title

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Date

Please provide this fully completed Authorization to the Executive Director or Director of Nursing at the Community. Please allow 30 days for review of the Authorization and supporting documents, copying of the records, and delivery.