ReMed
Release of Information Authorization

Print Name of Client: ______________________________

Client's Birthdate:______________ Client's Social Security Numbers:______________

This form authorizes: RECORDS DEPOSITION SERVICE, INC.
PO BOX 5054
SOUTHFIELD, MI 48086-5054
T: 248.357.3330
F: 248.357.3337

(Person or class of persons authorized to make the disclosure/Relationship to client)

To use, disclose or exchange information with ______________________________

(Person or class of persons to whom ReMed may make the disclosure/Specify Relationship to client)

The following relevant and timely information (the exact information and format must be specified, e.g., verbal discussion, written reports, etc., and the dates of treatment requested, if applicable):

____.

____

This information is requested for the purpose of: DISCOVERY BEFORE TRIAL

____

X This authorization is valid beginning on______________________ and for one (1) year ending on ______________.

You have been informed that you have the right to revoke consent at any time by oral or written request made to the Privacy Director at: ReMed, Clinical Services Dept., 16 Industrial Boulevard, Suite 203, Paoli, PA 19301, #484-595-9300, except to the extent that action has been taken in reliance on this authorization. So long as this authorization does not relate to treatment, payment or healthcare operations at ReMed, then you may refuse to sign this authorization without in any way affecting your treatment here.

You understand that the information to be released may contain information about HIV or AIDS or treatment for alcohol abuse, drug abuse, psychotherapy or treatment of mental illness. You have been informed of your rights under federal regulations concerning the release of alcohol/drug use and/or abuse treatment records (42CFR Part2). If you are a Pennsylvania resident, you have been informed of your rights under regulations issued under the Pennsylvania Mental Health Procedures act (55 PA Code 5100.33) and under the Pennsylvania Drug and Alcohol Abuse Control Act, to inspect the material to be released.

It is possible that information disclosed under this authorization might be disclosed by the recipient and no longer be protected.

This form has been fully explained, and I certify that I understand its contents.

Signature of Client:______________________________ Date:______________

Signature of Person Authorized in Lieu of Client:______________________________

Relationship to Client:______________________________ Date:______________

Witnessed by:______________________________ Date:______________

☐ **Copy Given to Client/Guardian**

Upon completion, the client/guardian receives a Copy and the Original should be placed in the Legal section of the client's primary chart.