SPECTRUM HEALTH

MEDICAL RECORD NUMBER _____

Authorization
RELEASE OF MEDICAL INFORMATION

Patient name _____ Date of birth _____

Maiden name _____

Phone _____ Last 4 digits of Social Security number _____ (optional)

Address _____

City _____ State _____ Zip _____

RECORD RELEASE:

I authorize my records to be sent FROM:

Name/Organization _____

Address _____

City _____ State _____ Zip _____

I authorize my records to be sent TO:

Name/Organization RECORDS DEPOSITION SERVICE, INC. P: 248-357-3330 F: 248-357-3337

Address PO BOX 5054

City SOUTHFIELD State MI Zip 48086-5054

DATES OF SERVICE _____

_____

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INFORMATION REQUESTED

- ☐ Abstract record
- ☑ Billings, invoices and statements
- ☐ Consults
- ☐ Discharge summary
- ☐ EEG/ECG/EMG
- ☐ Emergency record
- ☐ History and Physical
- ☐ Information related to visits with prior physicians and/or treatments by other physicians
- ☐ Records related to specific problem of _____
- ☐ Inspection Only
- ☐ Immunization record
- ☐ Lab reports
- ☐ Office visit
- ☐ Procedure reports
- ☐ Pathology reports
- ☐ X-ray reports
- ☐ X-ray images
- ☐ Entire record
- ☐ Other _____

is required or permitted by law, regulation, or written authorization by the patient.

OVER →

DO NOT MARK BELOW THIS LINE BARCODE ZONE DO NOT MARK BELOW THIS LINE

X01743

PURPOSE OF DISCLOSURE

☐ Patient request ☐ Attorney/Legal ☐ Insurance ☐ Continued Patient Care
☐ Other (specify) _____

It is further understood that the information released is for the specific purpose stated above and may not be provided in whole or in part to any other agency, organization or person, except as required by law. I further understand that correspondence, patient discharge instructions and records from other health care providers will be released with this routine request. I also acknowledge that Spectrum Health assumes no responsibility or liability for the accuracy or legitimacy of any records originating with a non-Spectrum Health provider.

If you *DO NOT WANT* any of the specific information below released, Check the box(es) below:

☐ Information about communicable diseases and serious communicable diseases and infections, as defined by statute and Michigan Department of Public Health Rules, which include venereal disease "VD", tuberculosis, "TB", hepatitis B, human immunodeficiency virus "HIV", HIV test, acquired immunodeficiency syndrome "AIDS", and AIDS related complex "ARC" and _____ (specify other if known).

☐ Alcohol and drug abuse treatment information protected under the regulations in 42 code of Federal Regulations, Part 2.

☐ Mental health treatment records, psychological services and social services information, including communications made by me to a social worker or psychologist.

☐ The release of my DNA test result regarding a diagnosis of _____
(Such as Huntington disease, breast cancer (BRCA1, BRCA2), colon cancer, polycystic kidneys, cystic fibrosis, etc.)

This authorization will expire sixty (60) days from the date of my signature unless I specify otherwise

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This authorization may be revoked in writing at any time as outlined in the Spectrum Health Joint Notice of Privacy Practices. Spectrum Health may not require this authorization as a condition for providing treatment, payment enrollment or eligibility for benefits. There is potential that information disclosed under this Authorization may be disclosed by the recipient and may no longer be protected by Federal HIPAA regulations.

_____ _____
Patient or Legal Representative signature **Date**

_____ _____
Basis of legal authority to act for patient Witness (second witness if signed with an "x")

Identification (ID) checked? ☐ Yes ☐ No License # _____
Copy of authorization given/sent? ☐ Yes ☐ No
Copies were: ☐ Mailed ☐ Picked up
H.I.M. to mail? ☐ Yes ☐ No
Fee letter sent? ☐ Yes ☐ No

Confidentiality of this medical record [illegible] except when use or disclosure is required or permitted by law [illegible] by the patient