800 S. WASHINGTON AVE.
SAGINAW, MICHIGAN 48601
PHONE: 989-907-8081
FAX: 989-907-8697

patient label

MR#___________________

HIPAA AUTHORIZATION FOR THE USE OF DISCLOSURE OF HEALTH INFORMATION

Last 4 digits of SS# ___________________

Please Print

Patient's Name: ______________________________________ ___________________
Last First Middle Date of Birth

Address: ______________________________________ (____)___________
Street City State Zip Telephone

1. **RELEASE INFORMATION FROM**: By signing below, I hereby authorize ______________________ (provider, healthcare organization, clinic, facility, etc.) to release information contained in my medical record (protected health information).

2. **RELEASE INFORMATION TO**: I authorize the above to release the protected health information defined below to

RECORDS DEPOSITION SERVICE, INC., PO BOX 5054, SOUTHFIELD, MI, 48086-5054
(provider, healthcare organization, clinic, facility, employer, or authorized person)

3. **WHAT SHOULD BE RELEASED:**

☑ ONLY THESE SPECIFIC DOCUMENTS: PLEASE SEE ATTACHED SUBPOENA FOR RECORDS WANTED

☐ MY MEDICAL RECORD FOR THE DATES: ____________________ ☐ MY ENTIRE MEDICAL RECORD(S)

4. I am requesting that the information be released for the following purpose(s):
   ☐ CONTINUED MEDICAL CARE ☑ LEGAL MATTER ☐ PAYMENT ☐ OTHER

5. I understand that the records to be disclosed may contain information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV), behavioral or mental health services, hepatitis, tuberculosis, and treatment for alcohol and drug abuse.

6. Expiration Date: ☐One year after the date signed ☐ Other______________________
   If not specified this authorization is only good for the date signed below.

7. I understand that I have the right to revoke this Authorization, EXCEPT:
   - If the information authorized to be released has already been released, or
   - If this Authorization was given as a condition of obtaining insurance coverage, other law provides that the insurance company has the right to contest a claim under the insurance policy.

8. I understand that I may revoke this Authorization by sending a written request to the attention of the Privacy Officer at the organization releasing this information.

9. I understand that once the information is released in accordance with this authorization, the information may be redisclosed by that party, and the privacy of my Protected Health Information may no longer be protected by the law.

10. I understand that there may be a fee associated with this request. If there is a fee, I expect the organization to contact me before copies are made.

By signing this Authorization, I acknowledge that I have read and understand this Authorization. Further, I authorize the use or disclosure of my Protected Health Information in accordance with the terms of this Authorization.

Signature (Patient) Date ___________ Signature (Authorized Representative) Date ___________

Printed Name of Person Signing ___________ Relationship to Patient ___________

☐ ID Verified (In person)
If submitting via mail - send a copy of your ID or Drivers License

Witness Date ___________

ALL AREAS MUST BE COMPLETE FOR THIS FORM TO BE A VALID REQUEST.