United Memorial Health Center

615 South Bower, Greenville, MI 48838

PATIENT'S AUTHORIZATION FOR DISCLOSURE OF HEALTH RECORDS
(Surgical/Medical/Alcohol & Drug Abuse/Social Service/Psychological)

PATIENT'S NAME _____ _____
Last First Initial Birthdate

ADDRESS _____ _____
Street City State Zip Phone

The undersigned hereby authorizes and requests United Memorial Health Center to provide information in my patient records, including as applicable:

Alcohol and drug abuse and mental health treatment information protected under the regulations in Title 42 of Code of Regulations Part II.

Information about human immunodeficiency virus - HIV, acquired immunodeficiency syndrome- AIDS, and AIDS related complex - ARC, as defined by Department of Public Health rules (1989 Public Act 174).

Name RECORDS DEPOSITION SERVICE, INC.
PO BOX 5054
SOUTHFIELD, MI 48086-5054

Address P: 248-357-3330 F: 248-357-3337

Name and address of person(s) or organization(s) to whom information is to be given access to my medical/hospital records for the purpose of review and examination and further authorizes and requests that you provide such copies thereof as may be requested.

SPECIFIC TYPE OF INFORMATION TO BE DISCLOSED FROM: _____

[ ] Complete Copy of Chart [ ] Emergency Room Reports [ ] Discharge Summary
[ ] Consultation Records [ ] History & Physical [ ] Laboratory Reports
[ ] Operative Reports [ ] X-ray Reports [ ] Other _____

PURPOSE AND NEED FOR SUCH DISCLOSURE

[ ] Court Request [ ] Patient Request [ ] Attorney Request
[ ] Continued Care [ ] Insurance Audit [ ] Other _____

I understand that this authorization will automatically expire once the purpose for which it was signed is accomplished. I also understand that I may revoke this authorization in writing at anytime, unless some action has been taken by United Memorial Health Center based on this consent.

I have read the above, and acknowledge that I fully understand the terms and conditions of this authorization.

SIGNATURE OF PATIENT _____ DATE _____

If patient is unable to sign or a minor, complete the following:

_____ _____ DATE _____
Parent/Responsible Relative/Guardian Relationship

SIGNATURE OF WITNESS _____ DATE _____