Authorization for Release of Protected Health Information

I hereby authorize the Washtenaw Health Plan to provide the following information:
Please see enclosed Subpoena or Letter Request for information to be disclosed.
(Describe specific information to be used)
to RECORDS DEPOSITION SERVICE, INC., PO BOX 5054, SOUTHFIELD, MI 48086-5054 P: 248-357-3330 F: 248-357-3337 for the purposes
(Person/persons who will use the information)
of FOR DISCOVERY BEFORE TRIAL

Washtenaw Health Plan Enrollee: _____ Birth Date: _____

My signature means that I have either read this form and/or have had it read to me and explained in language I can understand. I know what information is being disclosed. I know that unless I limit the type of information to be disclosed where indicated above, this information may include information related to general medical care, alcohol and drug abuse treatment, psychiatric/psychological treatment, social worker counseling, and information relating to communicable diseases such as HIV, AIDS or AIDS-related complex (ARC), venereal diseases, tuberculosis and hepatitis as well as claims and billing information.

The Effective Date of this authorization to release information is _____ (Current Date). It will remain in effect for one year after the effective date. I understand that I may revoke this authorization at any time, except to the extent that the Washtenaw Health Plan has taken action in reliance upon it. To revoke this authorization, I must send a written revocation to the Washtenaw Health Plan at the following address:

Washtenaw Health Plan
Privacy Officer
P.O. Box 30125
Lansing, MI 48909

I know that I may refuse to sign this authorization, because signing it is not a condition to treatment, payment, enrollment or eligibility for benefits. If I do sign, I know that I have right to receive a copy of this authorization after it is signed, because the Washtenaw Health Plan requested this authorization. I understand that the persons to whom information is disclosed under this authorization may re-disclose it to others without my knowledge, but only to the extent consistent with the authorized purpose stated above and then only to the extent otherwise allowed by law.

Signed: _____ Date: _____
(Washtenaw Health Plan Enrollee /Authorized Representative's Signature)

PLEASE COMPLETE THE FOLLOWING INFORMATION **ONLY** IF YOU ARE AN AUTHORIZED REPRESENTATIVE
If signed by an Authorized Representative, a description of the Representative's authority must be provided. Examples include custodial parent of a minor, legal guardian of an individual, patient advocate named by the individual in a patient advocate designation or other durable power of attorney for health care:
Type of Authorized Representative _____

Address: _____ Phone: _____
_____

Witness: _____ Date: _____
The witness ensures that the person signing understands the contents of this consent/release.