Anderson Hospital
6812 State Route 162 – Suite 175, Maryville, IL 62062
Phone: (618) 391-6102 Release of Information
Fax: (618) 288- 0024

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION ("PHI")

PHI To Be Disclosed By
ANDERSON HOSPITAL
6800 STATE ROUTE 162
MARYVILLE, IL 62062

PHI To Be Disclosed To (Specify Name, Address, Phone):
RECORDS DEPOSITION SERVICE, INC.
PO BOX 5054, SOUTHFIELD, MI, 48086-5054
P: 248-357-3330 F: 248-357-3337

Patient's Name:_____ **Date of Birth**_____

Patient's Address/Phone: _____

Date(s) of Service of PHI To Be Disclosed: From Date: _____ To Date: _____

Please Specify PHI To Be Disclosed:.

☐ Final Diagnosis	☐ X-ray Reports	☐ Mammogram with Report
☐ Discharge Summary	☐ Laboratory Reports	☐ Physician Orders
☐ History / Physical	☐ EKG	☐ Emergency Record
☐ Consultation Reports	☐ Pathology Reports	☐ ENTIRE RECORD
☐ Operative Reports	☐ Progress Notes	☑ Other (specify) PLEASE SEE ATTACHED SUBPOENA

Please Specify Purpose of Disclosure:

☐ Treatment or Consultation	☐ At the request of the patient	☐ Billing or Claims payment
☐ Legal	☑ Other: PRE TRIAL DISCOVERY	

- I understand that I have the right to revoke this Authorization at any time by submitting a notice in writing to address above, Attention of Release of Information—Health Information Management Department, and that the revocation will be effective except to the extent that action has already been taken in reliance on this Authorization.
- I understand that the information disclosed by this Authorization may be subject to re-disclosure by the recipient and no longer protected by Federal or state privacy requirements.
- I understand that treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing the Authorization.
- If PHI to be disclosed contains information about drug/alcohol abuse, mental health treatment, genetic information, sexually transmitted diseases, HIV/AIDS testing/treatment or any other sensitive information, I agree to its release.
  Check if you do not agree to release of sensitive information described herein: ☐ **Do Not Agree**
  Specify the information NOT to be released: _____
- Unless earlier revoked as provided herein, this Authorization will expire 180 days from the date of my signature below, unless a different expiration date/event is specified here_____.

By signing this Authorization, I hereby authorize disclosure of protected health information of above named patient as specified in this Authorization.

_____ _____
Signature of Patient or Personal Representative Date

If this Authorization is signed by the patient's personal representative: Specify below the personal representative's printed name, indicate personal representative's authority to act on behalf of the patient and attach supporting documentation:

_____
Personal Representative's Printed Name/Authority to Act on Behalf of Above Named Patient