bellinhealth

Revised 12/17/15

CORAUT

HEALTH INFORMATION DISCLOSURE AUTHORIZATION

Patient Name ☐ emancipated minor

Date of Birth

Address

City, State, Zip

Phone Number

AUTHORIZES:

Name of Health Care Provider

Address

TO RELEASE PROTECTED HEALTH INFORMATION TO:

RECORDS DEPOSITION SERVICE, INC.

Facility/Program/Person receiving information

248-357-3330

Phone Number

248-357-3337

Fax Number

PO BOX 5054, SOUTHFIELD, MI, 48067-5054

Address

INFORMATION TO BE USED OR DISCLOSED: Dates of service to include: _____

☐ Allergy Records	☐ EKG	☐ Orders
☐ Anesthesia Record	☐ History & Physical Exam	☐ Progress Notes
☐ Cardiac Catheterization	☐ Immunizations	☐ Surgical Reports
☐ Consultation Reports	☐ Psychiatric Evaluation	☐ X-ray/Imaging Reports
☐ Discharge Instructions	☐ Psychological Evaluation	☐ Social Service Assessment
☐ Discharge Summary	☐ Laboratory Reports	

☑ Other (specify) PLEASE SEE ATTACHED SUBPOENA OR LETTER REQUEST

(If "all" records is specified, only last 2 years will be provided.)

In compliance with Wisconsin and Michigan Statutes, which require special permission to release otherwise privileged information, please release records pertaining to:

☐ Alcohol & Other Drug Abuse	☐ Mental/Behavioral Health	☐ Developmental Disabilities
☐ HIV	☐ Other (specify) _____	

PURPOSE OR NEED FOR THIS DISCLOSURE: (check all applicable)

☐ At the request of individual	☐ Further Medical Care	☐ Legal Investigation or Action
☐ Changing Physicians	☐ Insurance Eligibility/Benefits	

☑ Other (specify) PRE TRIAL DISCOVERY

EXPIRATION DATE OF THIS AUTHORIZATION:

If not previously revoked, this consent will terminate: ☐ after the above information has been released or ☐ in one year.

If custodial parent, have you ever been denied physical placement of the above minor? ☐ Yes ☐ No ☐ NA

Do you have legal custody of the minor listed above? ☐ Yes ☐ No ☐ NA

I have had an opportunity to review and understand the content of this two-sided authorization form. By signing this form, I understand and agree with the content.

Signature of Patient or person legally authorized to sign for patient (date/time)

Printed name of person signing above

Witness (date/time)

If other, indicate relationship:

- ☐ Custodial Parent
- ☐ Court Appointed Guardian
- ☐ Health Care Agent
- ☐ Personal Representative

CORAUT

REDISCLOSURE: I understand that if the person(s) and/or organization(s) listed above are not health care providers, health plans or health care clearinghouses, who must follow the federal privacy standards, the health information disclosed as a result of this authorization may no longer be protected by the federal privacy standards and my health information may be redisclosed without obtaining my authorization.

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:

- **Right to Receive a Copy of this Authorization:** I understand that if I agree to sign this authorization, which I am not required to do, I must be provided with a signed copy of the form.
- **Right to Refuse to Sign this Authorization:** I understand that I am under no obligation to sign this form. The person(s) and/or organization(s) listed above whom I am authorizing to use and/or disclose my information may not condition treatment, payment, enrollment in a health plan or eligibility for the health care benefits on my decision to sign this authorization.
- **Right to Withdraw this Authorization:** I understand written notification is necessary to cancel this authorization. To obtain information on how to withdraw my authorization or to receive a copy of my withdrawal, I may contact the facility where the authorization was originally created.
  I realize that if I cancel this authorization, it will not affect uses and/or disclosures of my information that have already occurred based upon my authorization.

Photocopy/fax copy is as valid as the original.

Note to the patient: If information is released under Wisconsin Statute 51 – State Alcohol, Drug Abuse, Developmental Disabilities and Mental Health Act, the patient has a right to inspect and receive a copy of the material to be disclosed as required under ss. HFS Confidentiality of Treatment Records 92.05 and 92.06.

Note to the patient and recipient of information: Bellin Health reserves the right to assess a charge for labor and supplies for making photocopies. This disclosed information is protected under Federal Law titled Standards for Privacy of Individually Identifiable Health Information 45 CFR Parts 160 & 164 and by Wisconsin Statute 146.82 Confidentiality of Patient Health Care Records, 51.30 Mental Health Act, and 146.83 Access to Patient Health Care Records. Federal regulations prohibit you from making any further disclosure of this information without specific written consent of the person to whom it pertains or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose.

For Medical Records Use Only: Date _____ # Pages _____ Date _____ # Pages _____