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# AUTHORIZATION FOR RELEASE OF MEDICAL/PSYCHIATRIC INFORMATION

PATIENT'S NAME: _____

GIVE: _____

My authorization to release confidential information regarding my medical/psychiatric status to:

RECORDS DEPOSITION SERVICE, INC.
PO BOX 5054, SOUTHFIELD, MI 48086-5054
P: 248-357-3330 F: 248-357-3337 E: REQUESTS@RECDEP.COM

The following types of information are specially authorized for release:

____ Initial Evaluation
____ Progress Notes
____ Medication Report
____ Discharge Summary
____ Hospital Admission History & Physical
____ X-Rays
____ Laboratory Reports
[✓] Other: PLEASE SEE THE ATTACHED SUBPOENA OR LETTER REQUEST

_____ _____
Patient's Signature Date

_____ _____
Witness' Signature Date

Patient's Date of Birth _____

Patient's Social Security Number _____