RUSH

Rush Copley Medical Group

AUTHORIZATION TO RELEASE HEALTH INFORMATION
There may be a fee for copies

Patient Name_____

Date of Birth____/____/____ Telephone (____)_____

I hereby authorize Rush Copley Medical Group to:

RELEASE TO: OBTAIN FROM:

Person/Facility Agency RECORDS DEPOSITION SERVICE, INC _____
Address PO BOX 5054 _____
City, State, Zip SOUTHFIELD, MI 48086-5054 _____

Specific description of information that may be used/disclosed:

- ☐ Office Visit Notes — Dates of Treatment_____
- ☐ Diagnostic Tests (labs, X-ray, EKG) — Dates of Treatment_____
- ☐ Consultation Notes — Dates of Treatment_____
- ☐ Immunization Records — Dates of Treatment_____
- ☐ Patient Messages
- ☐ Please provide complete medical record (includes all of the above) — Dates of Treatment_____
- ☐ Other_____

The information will be used/disclosed for the following purpose:

☐ Continuing Care ☐ Personal ☒ Legal ☐ Other_____

I authorize Rush Copley Medical Group to release sensitive information as indicated:

☐ AIDS/HIV ☐ Drug/Alcohol Abuse ☐ Behavioral Health ☐ Sexual Assault
☐ Child Abuse ☐ Developmental Disabilities ☐ Genetic Testing

I prefer my records to be provided in the following format:

☐ Paper ☒ Electronic on a data disk OR: E-MAIL TO INFO@RECDEP.COM
UPLOAD AT WWW.RECDEP.COM

I understand that this authorization is voluntary and that I may refuse to sign this authorization. Unless allowed by law, my refusal to sign will not affect my ability to obtain treatment, receive payment, or eligibility for benefits.

I understand that I may revoke this authorization at any time by notifying the person/organization providing the information in writing. However, the revocation will not be valid if:

(a) Action has been taken in reliance on this authorization, or
(b) If this authorization is obtained as a condition for obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy or the policy itself.

I understand the information I authorize a person or entity to receive may be redisclosed and no longer protected by federal privacy regulations.
This authorization will expire on the following date, event, or conditions:

_____
_____

Signature

_____ Patient	_____ Date
_____ Personal Representative	_____ Relationship to Patient
_____ Witness	_____ Relationship to Patient

We are required by law to respond to this request within 30 days of receipt of the request.