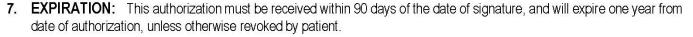


AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

For Office Use Only:
Patient MRN:

1.	ATIENT INFORMATION: Please print clearly. All information must be provided.							
	Full Legal Name:							
	(First)	(Last)	(Middle Initial)					
	Current Address: (Street)	(City)	(Zip)					
	Telephone Number:		Date of Birth:					
2.	HEREBY AUTHORIZE AND REQUEST (Please check only one location per authorization):							
	SwedishAmerican Hospital	* <u></u>	Other (Name of facility/person and address):					
	SwedishAmerican Medical Center Belvidere							
	SwedishAmerican Home Care SwedishAmerican Medical Group (SAMG):							
	(specify clinic location)							
3.	TO RELEASE, USE AND/OR DISCLOSE THE FOLLOWING HEALTH INFORMATION:							
	Abotrost of above only (included distated reports and discrepation to the popular such as left asset in any and							
	Abstract of above only (includes dictated reports and diagnostic test results such as lab results and x-ray reports) Entire medical record (includes abstract and nursing notes, progress notes, physician orders, etc.)							
	Medical Imaging (Radiology) Films (X-rays, CT, MRI, Ultrasound, Cardiovascular, etc.)							
	X Other (specify) PLEASE SEE ATTACHED SUBPOENA OR LETTER REQUEST							
RELATING TO THE FOLLOWING TREATMENT OR TIME PERIOD:								
	RELATING TO THE FOLLOWING TREATMENT ON TIME FERIOD.							
	From (date) t	0	(date).					
4	THE INFORMATION MAY BE RELEASED TO):						
N	(Name of facility/person and address)		EPOSITION SERVICE, INC.					
		PO BOX 5054, SOUTHFIELD, MI, 48086-5054						
		P: 248-357-3330 F	:248-357-3337 INFO@RECDEP.COM					
5.	THE PURPOSE(S) OR NEED FOR THIS DISC	CLOSURE IS:						
	☐ Medical Care ☐ Insurance Purposes ☐ At the request of the patient							
	Other: PRE TRIAL DISCOVERY	· · · · · · · · · · · · · · · · · · ·						
6.	FORMAT: Please check only one box. If format is not selected, records will be in paper format.							
		. In the contract of the contr						
	☐ Secure electronic access (for SAMG clinic records only – internet access and valid email address required) Email address:							
	Select a PIN:(up to 10 digits—if not chosen, date of birth will be used)							
	(up to 10 digits—it not chosen, date of birth will be used)							





	If transfer is due to patient disconti ☐ Insurance Requirement ☐ Dissatisfaction	nuing services of physicial Physician Availability Relocation						
9.	PLEASE READ THE FOLLOWING CAREFULLY:							
I understand that I may revoke this Authorization in writing at any time, except to the extent information was released or other action taken in reliance on it. Any written revocation must be signed by the patient or legal representative, witnessed, and delivered to the Privacy Official, SwedishAmerican Health System, and 1401 E. State St., Rockford, IL 61104.								
I understand the potential for further disclosure by recipients of the information to persons who may not be subject to privacy or confidentiality protections.								
I understand that the above identified health information may contain mental health, developmental disabilities, alcohol and drug abuse, and/or Acquired Immune Deficiency Syndrome (AIDS) HIV test results and/or information.								
I understand that I have the right to inspect and copy the information that is requested to be released pursuant to this Authorization.								
I understand that I may refuse to sign this Authorization, and that no treatment, payment or benefits are conditioned upon my providing this Authorization. If I refuse to sign this Authorization, I understand that the disclosure described above cannot be made unless it is authorized or required by law.								
	nature of Patient or Legal Represen tients ages 12-17 may be required t		ationship to Patient	Date				
Via 1001	Commence Com							
Co-	Signature	Rela	tionship to Patient	Date				
Sig	nature of Witness			Date				



8. FOR CLINIC USE ONLY: