AUTHORIZATION FOR OBTAINING OR RELEASING CONFIDENTIAL INFORMATION

I, ______________________________ *of* ____
(Patient Name) (Number & Street)

____
(City, State) *(Zip Code)*

Date of Birth: ____________________ ***Social Security Number:*** *xxx-xx-*______________

Authorize: *The Renfrew Centers*
☑ **To Release**
☐ **To Obtain**

( ) Progress Notes ( ) Interdisciplinary Assessments ( ) Treatment Summary
( ) Discharge Summary ( ) Radiology Results ( ) Physician Orders
( ) Admission Evaluation ( ) Psychological Testing ( ) Laboratory Results
( ) Psychiatric Evaluation ( ) HIV Testing ( ) Treatment Plan(s)
( ) History and Physical ( ) Medication Records (✓) Other: PLEASE SEE ATTACHED SUBPOENA OR LETTER REQUEST
( ) Verbal Exchange: ______________________________

To/From: Organization and / or Person: RECORDS DEPOSITION SERVICE, INC. Relationship to Patient: AGENT FOR ATTORNEY

Address: PO BOX 5054, SOUTHFIELD, MI 48086-5054

Telephone Number: 248-357-3330 Fax/Email Address**: 248-357-3337 / INFO@RECDEP.COM

I hereby authorize **The Renfrew Center** to release / obtain copies of **Psychiatric, Drug and Alcohol, HIV, and Medical Information** from the health care record pertaining to my hospitalization / treatment by mail, courier, telephone conversation, electronic mail, or facsimile transmittal to or from.
Dates of Service: *(check at least one)*
_____ Most recent 6 (six) months _____ Specific dates of service requested to release/obtain: ____________________

These records are required for the purpose of: *(check at least one)*
___ Providing information to health care providers ☑ Legal Purposes ____ Social Security / Disability
___ Other: *(specify)* ____

Please initial the following:

___ I understand that my healthcare and payment for healthcare will not be affected if I do not sign this form, and I am entitled to a copy of this form after I sign it.
___ I understand that this document allows the parties identified above to release/obtain information for the dates of service identified and for care received within one year of the signature date unless otherwise revoked.
___ I understand that my records are confidential and will not be disclosed without my written consent unless under legal compulsion. I also understand that this authorization expires exactly one year from the date of my signature below.
___ I understand that I may revoke this authorization (except to the extent that action has been taken in reliance thereon) at any time by written and dated communication to the Medical Records Department at The Renfrew Center.
___ **I understand that by providing an address for electronic mail as listed above I agree to the electronic exchange of information over the internet and understand the risks associated with this mode of communication.

This information has been disclosed to you from confidential records protected by state and federal laws; those laws that are more stringent will apply. Any further disclosure of this information is not permitted with out specific authorization to do so.

I certify that this form has been fully explained to me and that I understand its contents.

Signature of Patient: ______________________________ Date: __________

Signature of Parent / Guardian: ______________________________ Date: __________

Signature of Renfrew Staff: ______________________________ Date: __________

Sign below only if you wish to Refuse or Revoke your authorization

I hereby acknowledge that I have been asked to sign the above release of confidential information and elect to **REFUSE /REVOKE PERMISSION.**

Signature of Patient: ______________________________ Date: __________

Signature of Parent / Guardian: ______________________________ Date: __________

Signature of Renfrew Staff: ______________________________ Date: __________

Refuse/Revoke

Revision: 7/19

This form complies and remains in accordance with the Health Insurance Portability And Accountability Act of 1996 (HIPAA). You May Refuse To Sign This Authorization.

VERBAL AUTHORIZATION

**** Verbal Authorizations may only be permissible in certain states. Check your state regulations for more information. ****

1) **Page One must be filled out completely and reviewed with the patient prior to obtaining Verbal Authorization to Release Information.**
2) **Confirm the validity of the requestor by obtaining the "Patient Identifiers" listed below.**
3) **Verbal Authorization is to be used in only the most urgent circumstances that will not allow for written authorization to be obtained.**
4) **Staff will make every effort to obtain written authorization once the patient and/or parent is available for signature.**

Patient Identifier:

Patient Name: ________________________ Date of Birth: ____________________ Social Security #: xxx-xx-__________

Please complete the following:

☐ - Patient is unable to sign because: ____

☐ - Patient is a minor: ____________ years of age [**this box indicates verbal authorization was given by a minor and their parent/guardian (where applicable by state law)**]

Name(s) of Parent/Guardian authorizing request to release/obtain information:

____

____

I witness that the patient identified above was physically unable to provide a signature at this time, but he/she demonstrated verbal understanding of the nature of this release and freely gave his/her oral authorization for staff at The Renfrew Center to release/obtain information regarding his/her Psychiatric, Drug and Alcohol, HIV and/or Medical healthcare Information. If the patient is a minor and per state law (where applicable), I witness that the parent/guardian was contacted and understood the nature of this release and gave his/her oral authorization to release/obtain the information above.

______________________	______________________	______________
Witness 1 Signature	Witness 1 Printed Name	Date

______________________	______________________	______________
Witness 2 Signature	Witness 2 Printed Name	Date

This form complies and remains in accordance with the Health Insurance Portability And Accountability Act of 1996 (HIPAA). You May Refuse To Sign This Authorization.