APRIA HEALTHCARE

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

Individual's Name: _____
Last First Middle

Home Address: _____
_____

Home Telephone: _____ Date of Birth: _____

DESCRIBE INFORMATION TO BE DISCLOSED. PLEASE BE SPECIFIC: _____
_____
_____
_____
_____
_____

MY HIGHLY CONFIDENTIAL INFORMATION:
By signing my name next to a category of highly confidential information listed below, I specifically authorize the use and/or disclosure of the type of highly confidential information indicated next to my signature, if any such information will be used or disclosed pursuant to this Authorization:

- Information about a Mental Illness or Developmental Disability _____
- Information about HIV/AIDS Testing or Treatment _____
  (including the fact that an HIV test was ordered, performed or reported, regardless of the results of such tests)
- Information about Venereal Disease _____
- Information about Substance (i.e., alcohol or drug) Abuse _____
- Information about Abuse of an Adult with a Disability _____
- Information about Sexual Assault _____
- Information about Child Abuse and Neglect _____
- Information about Genetic Testing _____
- Other state designated Highly Confidential Information _____

RECIPIENT: Name of person or class of persons to whom Apria Healthcare or my home healthcare provider may disclose my health information: **RECORDS DEPOSITION SERVICE, INC.**
_____

Address of the recipient or where my health information should be delivered:
PO BOX 5054
SOUTHFIELD, MI 48086 - 5054
P: 248.357.3330 F: 248.357.3337

TERM: This Authorization will remain in effect:
☐ From the date of this Authorization until the _ day of _____, 20____.
☐ Until Apria Healthcare or my home healthcare provider fulfills this request.
☐ Until the following event occurs: _____
_____
☐ Other: *Note: If treatment is related to the participation in a research study, an expiration date/event of "none" may be used.* _____
_____

Provide the patient with a copy of this signed Authorization

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PURPOSE: I authorize Apria Healthcare or my home healthcare provider to use or disclose my health information (including the highly confidential information I selected above, if any) during the term of this Authorization for the following specific purpose(s): *Note: "At the request of the patient" is sufficient if the patient is initiating this Authorization.* FOR DISCOVERY BEFORE TRIAL

REDISCLOSURE: I understand that once Apria Healthcare or my home healthcare provider discloses my health information to the recipient, neither Apria Healthcare nor my home healthcare provider, as the case may be, can guarantee that the recipient will not redisclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.

MARKETING: I understand that Apria Healthcare or my home healthcare provider may, directly or indirectly, receive remuneration from a third party in connection with the use or disclosure of my health information.

REFUSAL TO SIGN: I understand that I may refuse to sign this Authorization for any reason and that such refusal will not affect the commencement, continuation or quality of my treatment from Apria Healthcare or my home healthcare provider; except, however, that Apria Healthcare or my home healthcare provider may refuse to treat me if I do not sign this Authorization if my treatment by Apria Healthcare or my home healthcare provider is for the sole purpose of creating health information for disclosure to the recipient identified in this Authorization or if my treatment is related to my participation in a research study.

REVOCATION: I understand that I may revoke, at any time, this Authorization for any reason by providing a representative of Apria Healthcare or of my home healthcare provider with a written revocation, unless Apria Healthcare or my home healthcare provider, as the case may be, has already acted in reliance upon this Authorization or this Authorization was obtained as a condition of obtaining insurance coverage.

I understand that this Authorization will remain in effect until the term of this Authorization expires or I provide a written notice of revocation to a representative of Apria Healthcare or my home healthcare provider, as the case may be.

I have read and understand the terms of this Authorization and I have had an opportunity to ask questions about the use and disclosure of my health information. By my signature below, I hereby, knowingly and voluntarily, authorize Apria Healthcare or my home healthcare provider to use or disclose my health information in the manner described above and hereby acknowledge receipt of a copy of this signed Authorization.

Signature of Patient Date

If the patient is a minor or is otherwise unable to sign this Authorization, obtain the following signature:

Signature of Personal Representative Description of Authority Date

Provide the patient with a copy of this signed Authorization