Authorization To Release Medical Records:

PATIENT INFORMATION:

Name (print) DOB SSN

_____ _____ _____

INFORMATION TO BE RELEASED FROM:

Name of facility or provider

_____

Address

_____

INFORMATION TO BE SENT TO:

Name of designated receipient

RECORDS DEPOSITION SERVICE, INC.

Address	City	State	Zip
PO BOX 5054	SOUTHFIELD	MI	48086-5054

INFORMATION TO BE RELEASED: (check one)

_____ The most recent 2 years of pertinent information (chart notes, labs, x-rays and special tests)
_____ All medical records
_____ Specific information (please specify) :

PURPOSE FOR WHICH THE DISCLOSURE IS BEING MADE: (please check one)

_____ Attorney _____ Insurance _____ Doctor _____ Personal

PATIENT AUTHORIZATION :

I understand that my records may contain information regarding the diagnosis or treatment of HIV/AIDS, sexually transmitted diseases, drug and/or alcohol abuse, mental illness, or psychiatric treatment. I give my specific authorization for these records to be released.

* EXCLUDE the following information from the records released (please initial)

_____ Drug / Alcohol abuse/treatment & diagnosis _____ Sexually transmitted disease
_____ HIV/AIDS diagnosis/treatment/testing _____ Mental illness or psychiatric diagnosis/treatment

MY RIGHTS:

I understand I do not have to sign this authorization in order to obtain health care benefits (treatment, payment or **enrollment). I may revoke this authorization in writing. To view the process for revoking this authorization, please read the** Privacy Notice to patients posted at the facility where your information is being released. I understand that once the health information I have authorized to be disclosed reaches the noted recipient, that person or organization may re-disclose it, at which time it may no longer be protected under Privacy laws.

Signature: _____ Date: _____

(Patient, guardian*, or Authorized representative*)

This authorization will expire 90 days from the date signed
Possible copying fee required