COMMUNITY EMERGENCY MEDICAL SERVICE
AUTHORIZATION FOR DISCLOSURE OF
PROTECTED HEALTH INFORMATION

BY SIGNING THIS FORM, YOU ARE AGREEING THAT COMMUNITY EMERGENCY MEDICAL SERVICE, INC. (CEMS) MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION.

Name of Patient: ______________________ Date of Birth of Patient: ______________
Address of Patient: ____
Social Security Number ____________ and/or Medical Record Number of Patient: ______________

☐ I am the Patient
☐ I am the Personal Representative of the Patient, because (initial one):
____ I am the patient's custodial parent. *
____ I am the patient's legal guardian. **
____ I am the patient's Patient Surrogate. All conditions necessary for making the Surrogate designation effective have occurred. **
____ The patient is deceased. I am the properly appointed executor or administrator of the estate.**
* **Evidence of relationship may be required.**
** **Photocopies of all relevant documents must be attached.**

By signing this Authorization, I hereby request and authorize that CEMS, and its agents and employees, release the following Protected Health Information ("PHI") (initial one):

Specific PHI to be disclosed: ( ) Run Report ( ) Face Sheet ( ) Entire Record (X)
Other: SEE ATTACHED SUBPOENA.
I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

Purpose or need for disclosure: PRE-TRIAL DISCOVERY.

CEMS is authorized to Use or Disclose the PHI indicated above in the following manner:
Use of PHI By CEMS
____ Use PHI for CEMS Marketing Purposes. Exceptions: ______________________

____ Use PHI for Fundraising Purposes (Name & Address only). Exceptions: ______________

____ Use PHI for Other Purposes (describe): ______________________

Disclosure of PHI By CEMS To Other Individuals or Entities

Disclose To: Name: RECORDS DEPOSITION SERVICE
Organization: ______________
Address: P.O. BOX 5054
City/State/Zip: SOUTHFIELD, MI 48086-5054
(248) 357-3330

This Authorization expires ninety (90) days from the date signed below unless otherwise specified: ______________

Signed: ____________________ Date: ______________

Notarized signature may be required for Requests not made in person
Subscribed and Sworn Before me, This
________ Day of ____________, ________, A
Notary Public in and for ______________ County, Michigan.

____
Signature, Notary Public

_____(Initial) I have read the information about authorizations and understand that (a) I can revoke an authorization, with certain exceptions; (b) CEMS will still provide care to me even if I don't sign an authorization, unless special circumstances regarding research exist; and (c) once information is released outside CEMS and its agents, CEMS is not responsible for any further disclosure of the information.

4/08/03