279 Summit Drive Waterford, Michigan 48328 Phone: (248) 745-4900 Fax: (248) 745-6872
12800 East Warren Avenue, Detroit, MI 48215 Phone (313) 824-8000 Fax: (313)824-7779

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

I, _____, request and authorize **CNS Healthcare**, its designee, it's Health Information Services Manager, designee or Health Information Services Department to release **medical/psychiatric information including psychiatric, substance abuse, psychological, social services and medical information which may include information regarding Acquired Immunodeficiency Syndrome (AIDS), AIDS Related Complex and Human Immunodeficiency Virus (HIV) and/or other serious communicable diseases contained in the record of:**

Consumer Name: _____ **D.O.B.**_____ **Case #:**_____

To the individual(s) or organization listed below: **(name and address to whom the information is to be released):**

RECORDS DEPOSITION SERVICE, INC.

PO BOX 5054, SOUTHFIELD, MI 48086-5054

P: 248-357-3330 E: INFO@RECDEP.COM

Specific information to be disclosed:

PLEASE SEE ENCLOSED SUBPOENA OR REQUEST FOR INFORMATION.

Purpose and need of this requested information is: □ Coordination of Care ☒ Other LEGAL DISCOVERY

Duration of Authorization: I understand this authorization may be revoked in writing at any time, except to the extent that CNS Healthcare or the persons who work here, have already taken action in reliance upon it. It is valid only for the purpose, information, agencies and persons cited above. Unless otherwise revoked, this authorization will **expire in one year.**

Re-disclosure: I understand that my Protected Health Information that is used or disclosed under this Authorization may be subject to re-disclosure by the recipient, and the privacy of my Protected Health Information may no longer be protected by the law. Alcohol and drug abuse records disclosed to you from records protected by federal confidentiality rules (42 CFR Part2) prohibits you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Revocation of Authorization: I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Health Information Services Department. CNS Healthcare will not condition treatment or payment based on this authorization or revocation of the authorization unless otherwise allowed by law.

_____ _____
Consumer's Signature **Date** **Legal Guardian Signature (if applicable)** **Date**

_____
Witness Signature **Date**

This authorization has been prepared in accordance with the following authority: Public Act 56 of 1973; Title 45 of the Code of the Federal Regulations, CFR Part II: the Code of the Federal Regulations.42 CFR: the 1978 Michigan Public Act 368 as amended, Public Act 174 of 1989, Section 5131; and Section 748 of the Michigan Mental Health Code