



# HAVENWYCK HOSPITAL

## AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Social Security #: \_\_\_\_\_ Date(s) of Treatment: From \_\_\_\_\_ To \_\_\_\_\_

I hereby freely and voluntarily authorize Havenwyck Hospital to:

- Release/disclose my Protected Health Information to:
- Obtain my Protected Health Information from:

RECORDS DEPOSITION SERVICE, INC.  
 (Individual, Facility or Organization)  
 P.O. BOX 5054  
 (Address)  
 SOUTHFIELD, MI, 48086-5054  
 (City, State, Zip)

248-357-3330  
 (Phone Number)  
 248-357-3337  
 (Fax Number)

The purpose of this disclosure is for:

- Insurance
- Educational placement
- Legal reasons
- Medical treatment
- Discharge planning
- Continued treatment
- Patient
- Progress updates
- Other (explain) PRE TRIAL DISCOVERY

Information to be used or disclosed:

- Discharge Summary
- Psychiatric Evaluation
- Mental Status
- History & Physical
- Psychological Testing
- Treatment plan(s)
- Lab/X-ray results
- Progress Report
- Verification Letter
- Psychosocial Assessment
- Physician's Orders
- Substance Abuse Tx
- Aftercare Plan
- Other (explain) PLEASE SEE ATTACHED SUBPOENA OR LETTER REQUEST

- I understand that my medical records may contain information regarding testing, drug, and/or alcohol diagnosis and treatment; behavioral and/or mental health services and treatment; a communicable or venereal disease which may include, but is not limited to, diseases such as hepatitis, syphilis, gonorrhea, or the human immunodeficiency virus, also known as acquired immune deficiency syndrome (AIDS) and/or tuberculosis.
- I understand that such information is confidential and is protected by federal law.
- I understand that the provision of health care treatment to me cannot be conditional upon my agreement to sign an authorization for the discloser or use of my health information for purposes other than for treatment, payment and healthcare operations.
- I understand that the potential exists for health information that is released with my authorization to be re-disclosed by the recipient, and to be no longer protected by the Federal HIPAA law.
- I understand that I have the right to revoke this authorization at any time by giving written notice to Havenwyck Hospital Privacy Officer, except to the extent that action has already been taken in reliance on it.
- This authorization will expire 60 days following signature date unless another date or condition is specified.  
Other date or condition: \_\_\_\_\_

\_\_\_\_\_  
 (Patient signature) (Date)  
 \_\_\_\_\_  
 (Guardian or Representative) (Relationship to Patient) (Date)  
 \_\_\_\_\_  
 (Witness) (Date)

Drug and alcohol records are protected by Federal confidentiality ruling (42 CRF part 2) and require written consent to disclose this information unless otherwise permitted by 42 CRF part 2. Further disclosure is prohibited without written consent by the person to whom the information pertains unless otherwise permitted by the law. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.