HIPAA AUTHORIZATION TO RELEASE FORM

Individual Full Name ______________________

Individual Social Security Number/Medical Record Number ______________________

Address ______________________

Individual Date of Birth ______________________

City, State Zip Code ______________________

Individual Telephone Number ______________________

I hereby authorize use or disclosure of protected health information about me as described below.

1. The following specific person/class of person/facility is authorized to use or disclose information about me:
   HEALTH EMERGENCY LIFELINE PROGRAM
2. The following person (or class of persons) may receive disclosure of protected health information about me:

   RECORDS DEPOSITION SERVICE, INC.
   His/her/its Name

   P.O. BOX 5054
   Address

   SOUTHFIELD, MI 48086-5054
   City, State Zip Code
3. The specific information that should be disclosed is:

   PLEASE SEE THE ATTACHED SUBPOENA OR LETTER REQUEST
   FOR THE INFORMATION TO BE DISCLOSED

   ____

   UNLESS YOU SIGN HERE, NO INFORMATION ABOUT ALCOHOL/SUBSTANCE ABUSE, HIV/AIDS, OR MENTAL HEALTH WILL BE DISCLOSED:
   YES, DISCLOSE THIS INFORMATION * ______________
   NO, DO NOT DISCLOSE THIS INFORMATION * ______________
4. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal privacy regulations.
5. I may revoke this authorization by notifying ______________________ in writing of my desire to revoke it. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.
6. My purpose/use of the information is for ______________________________________.
7. This authorization expires on __________, 200___, OR upon occurrence of the following event that relates to me or to the purpose of the intended use or disclosure of information about me: ______________________.

FEES FOR COPIES: Federal and state laws permit a fee to be charged for the copying of records.

THIS FORM MUST BE FULLY COMPLETED BEFORE SIGNING – note that signature is required in two places.*

Signature of Individual* (The person about whom the information relates)	**Date of Individual's Signature**	**Date of Birth or Social Security Number**

OR, if applicable –

Signature of Guardian* or Personal Representative of Patient's Estate	**Date of Guardian's/Personal Representative's Signature**	**Description of Authority to Act for the Individual**

A copy of this completed, signed and dated form must be given to the Individual or other signator.