HealthSource
SAGINAW

Behavioral Medicine Services Rehabilitation Center Extended / Sub Acute Care

RELEASE OF INFORMATION AUTHORIZATION

I, _____, hereby authorize _____
(Person authorizing) (Provider requesting from)
to release information contained in _____(patient=s name) record(s), including alcohol and drug abuse records protected under the regulations in Code 42 of Federal Regulations, Part 2. If any; psychological services records, social services records, or psychiatric records including communications made by me to a social worker, psychologist or psychiatrist. If any; Human Immunodeficiency Virus (HIV), Acquired Immunodeficiency Syndrome (AIDS) and Aids Related Complex (ARC), communicable or infectious disease records (including venereal disease or tuberculosis records) as defined by Michigan Department of Public Health to the individuals or organizations listed under the conditions described below.

Patient's D.O.B.: _____ Former Name(s):_____

1. NAME of individual(s) or organization(s) to who disclosure is to be made:

   RECORDS DEPOSITION SERVICE, INC.

   ADDRESS: **PO BOX 5054, SOUTHFIELD, MI 48086-5054**

   PHONE: **248-357-3330** FAX: **248-357-3337**

2. SPECIFIC TYPE of information to be disclosed:

___History and Physical ___Discharge Summary ___Laboratory ___Consults
___Therapy Notes ___X-rays ___Initial evaluation
x Other **Please see enclosed Subpoena or Letter Request for information to be disclosed.**

3. I understand that I may revoke this consent at any time (to the Health Information Management Department) except to the extent that action has been taken in reliance of it, and that in any event this consent will expire ***6 months*** after the date of authorized signature unless another date is specified.

   CONSENT EXPIRATION DATE: ___/___/___ or EVENT_____

4. I understand that, if the person or entity receiving the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be redisclosed and no longer protected by these regulations.

All pertinent sections of this form must be *completed* before signing and dating

_____ _____
(Patient's Signature) (Date) (Witness)

_____ _____
(Guardian or Authorized Representative) (Date) (Relationship to patient/resident/client)