The Hospitalist Company

Patient Authorization to Release Information

(Please Print Clearly)

Patient Name: _____

Address _____

Phone_____ Date of Birth_____ Medical Record # _____

I authorize IPC to release medical information from my medical record to:

Name: RECORDS DEPOSITION SERVICE, INC.

Address PO BOX 5054

City/State/Zip SOUTHFIELD, MI, 48086-5054

The foregoing is subject to such limitation as indicated below:

- o Entire Record
- o Specific Information _____

I give special permission to release any information regarding: (initial on applicable line(s) below)

_____ Substance Abuse _____ Psychiatric/Mental Health _____ HIV Information

Reason for Request PRE TRIAL DISCOVERY

This authorization will automatically expire one year from the date signed. I understand that I may revoke this consent at any time except to the extent that action has been taken in reliance thereon.

Signed _____ Date _____

Witness _____ Date _____