Authorization for Release of Health Information

Name _____ Address _____

Social Security Number _____ City/State/Zip _____

Date of Birth _____

I request and authorize Livonia Family Physicians (Name of Practice) to release my health information that is in their possession which may include medical records and claims and billing information, including records regarding general medical care, alcohol and drug abuse treatment, psychological or psychiatric treatment, social services counseling, human immunodeficiency virus (HIV) or acquired immunodeficiency syndrome (AIDS) or AIDS related complex (ARC), communicable diseases or infections, venereal diseases, tuberculosis and hepatitis, and demographic information. I understand that Livonia Family Physicians (Name of Practice) will not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization.

Information to be disclosed (choose one):

- ☐ All of my health information
- ☐ My health information relating to the following treatment or condition(s): _____
- ☐ My health information for the following dates: _____
- ☐ All claims and billing information only
- ☐ Other: _____

Disclosure is to be made to: (name, address, phone)
RECORDS DEPOSITION SERVICE, INC.
PO BOX 5054
SOUTHFIELD, MI 48086-5054

T: 248.357.3330 F: 248.357.3337

Purpose of the disclosure:

- ☐ At my request
- ☐XX Other (specify) FOR DISCOVERY BEFORE TRIAL

This authorization expires (choose one)

- ☐ One year from the date it is signed
- ☐ On the following date: _____

I understand that I may refuse to sign the Authorization and that I may revoke it at any time but I must do so in writing to Livonia Family Physicians (Name of Practice) at the following address _____.

The revocation will not be effective to the extent that Livonia Family Physicians (Name of Practice) has already disclosed the information. I understand that I have the right to request a copy of this Authorization after it is signed if the Livonia Family Physicians (Name of Practice) requested it. I understand that the persons to whom information is disclosed under this Authorization may possibly re-disclose the information to others without my knowledge or consent and therefore the privacy of my personal and health information may no longer be protected by law.

_____ _____

Signature Date Signed

If signed by a person other than the patient, please indicate relationship and authority to do so:

_____ Legal Guardian _____ Power of Attorney

_____ Parent of minor child _____ Personal Representative of deceased