MARQUETTE GENERAL HEALTH SYSTEM

MARQUETTE, MICHIGAN

UPCARE® eMR Access__________

Authorization To Release Protected Health Information

(Required items are in BOLD type — PLEASE PRINT)

Patient Name:______________________________ **Birth Date:** ____/____/____

Previous Names:______________________________ **Social Security #:**______/______/______

Address:____________________ **City, State & Zip Code:**____________________ **Phone #:**______________

I authorize Marquette General Health System to release information concerning the patient identified above, in accordance with state and federal laws, to the following:

RECORDS DEPOSITION SERVICE, INC.	P: 248.357.3330 F: 248.357.3337
Name/Organization to Receive Information	*Phone Number*
PO BOX 5054	SOUTHFIELD, MI 48086-5054
Address	*City, State and Zip Code*

1. **Specific information to be disclosed** *(check all that apply or describe the information)*

   ☐ Discharge Summary ☐ Psychological Evaluations ☐ Progress Notes ☐ Substance Abuse
   ☐ History & Physical Examination ☐ Lab Reports ☐ Radiology/X-ray Reports ☐ Consultation Reports
   ☐ EKG/Stress Test ☐ Emergency Room Record ☐ Discharge Instructions ☐ Operative/Procedure Reports
   Other:______________________________ ☐ Home Health

   Medical conditions or approximate date(s) of treatment:______________________________

2. With the exception of psychotherapy notes, I authorize all information which may be contained in my medical records pertaining to psychiatric/mental health, chemical dependency, and/or AIDS/HIV related illness/testing to be released **unless** otherwise specified here:______________________________

3. **I am requesting this information be released for the following purpose:**

   ☐ Continued Care ☐ Insurance Claim ☐ Personal Use ☐ Attorney Review ☒ Other FOR DISCOVERY BEFORE TRIAL

4. I understand I may revoke this authorization by written request at any time. I understand that the revocation will not apply to information that has already been released in response to this authorization.

5. I understand there may be a fee to process this release of information.

6. This authorization will automatically expire on: ____/____/____ or one year from the date of my signature.

7. Marquette General Health System will not condition my continued treatment upon my signing this authorization, except for research-related treatment.

8. I understand that once my health information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure or release by the receiving Party and may no longer be protected by Federal or State law, unless protected by Federal Regulation 42 CFR Part 2 and Public Act 258 in which case it cannot be re-disclosed by the receiving Party without my written authorization.

9. I hereby agree to indemnify and hold Marquette General Health System, their employees and agents free and harmless from any actions against them for alleged invasion of privacy, libel or slander, or defamation arising from or related to disclosure of such information.

______________________________ ______________________________
Patient or Patient's Legal Representative's Signature *Date*

______________________________ ______________________________
**Print Legal Representative's Name and Relationship* *Witness*

REASON PATIENT IS UNABLE TO SIGN: ☐ Minor ☐ Deceased ☐ Other:______________________________

*☐ **AUTHORITY ATTACHED** (In non-emergency situations documentation of legal representative's authority to sign for the patient must be included).