# Authorization for Release of Protected Health Information

I hereby authorize the Mid-Michigan Health Plan to provide the following information:

_____,
(Describe specific information to be used)

to **RECORDS DEPOSITION SERVICE, INC.**
**PO BOX 5054**
**SOUTHFIELD, MI 48086-5054**
**P: 248-357-3330**
**F: 248-357-3337**

to be used for the purposes of **DISCOVERY BEFORE TRIAL .**

Mid-Michigan Health Plan Enrollee: _____ Birth Date _____

My signature means that I have either read this form and/or have had it read to me and explained in language I can understand. I know what information is being disclosed. I know that unless I limit the type of information to be disclosed where indicated above, this information may include information related to general medical care, alcohol and drug abuse treatment, psychiatric/psychological treatment, social worker counseling, and information relating to communicable diseases such as HIV, AIDS or AIDS-related complex (ARC), venereal diseases, tuberculosis and hepatitis as well as claims and billing information.

The Effective Date of this authorization to release information is July 10, 2008 (Current Date). It will remain in effect for one year after the effective date. I understand that I may revoke this authorization at any time, except to the extent that the Mid-Michigan Health Plan has taken action in reliance upon it. To revoke this authorization, I must send a written revocation to the Mid-Michigan Health Plan at the following address:

Mid-Michigan Health Plan
Privacy Officer
P.O. Box 30125
Lansing, MI 48909

I know that I may refuse to sign this authorization, because signing it is not a condition to treatment, payment, enrollment or eligibility for benefits. If I do sign, I know that I have right to receive a copy of this authorization after it is signed, because the Mid-Michigan Health Plan requested this authorization. I understand that the persons to whom information is disclosed under this authorization may re-disclose it to others without my knowledge, but only to the extent consistent with the authorized purpose stated above and then only to the extent otherwise allowed by law.

Signed: _____ Date: _____
(Mid-Michigan Health Plan Enrollee /Authorized Representative's Signature)

PLEASE COMPLETE THE FOLLOWING INFORMATION **ONLY** IF YOU ARE AN AUTHORIZED REPRESENTATIVE
If signed by an Authorized Representative, a description of the Representative's authority must be provided. Examples include custodial parent of a minor, legal guardian of an individual, patient advocate named by the individual in a patient advocate designation or other durable power of attorney for health care:

Type of Authorized Representative _____

Address: _____ Phone: _____
_____

Witness: _____ Date: _____
The witness ensures that the person signing understands the contents of this consent/release.