MILLENNIUM HEALTH

AUTHORIZATION FOR RELEASE OF HEALTH AND/OR BILLING INFORMATION

ATTN: MEDICAL DEPARTMENT

RE: _____

AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION

I, _____, authorize Millennium Health to disclose health information about me, as described below, to: RECORDS DEPOSITION SERVICE, INC.

PO BOX 5054, SOUTHFIELD, MI 48086-5054

1. The health information that may be used and disclosed includes (e.g., billing or claims information, lab test results (if you request lab test results be used or disclosed, given the nature of the Millennium Health lab test results, you are specifically authorizing the use and disclosure of drug and/or alcohol information)):

PLEASE SEE THE ATTACHED SUBPOENA OR LETTER REQUEST

In addition, to protect your privacy, the following types of information will be disclosed ***only if*** specifically authorized by you by **checking and initialing the appropriate box below**.

- ☐ Genetic Test Records and/or other Genetic Information _____ (initial)
- ☐ HIV/AIDS _____ (initial)
- ☐ Pregnancy/Family Planning _____ (initial)
- ☐ Psychiatric Information _____ (initial)
- ☐ Sexually Transmitted Diseases/Communicable Disease _____ (initial)
- ☐ Other: _____
- ☐ Exclusions: _____

Applicable Date Range(s): _____

2. This disclosure is being made for the following purposes:

LEGAL - DISCOVERY BEFORE TRIAL

3. I understand that this Authorization is voluntary and that my treatment, payment for treatment, health insurance enrollment or eligibility for benefits will not be affected if I refuse to sign this form, but if I do not sign this Authorization, Millennium Health cannot disclose health information about me.

4. I understand that I may change my mind and revoke (take back) this Authorization at any time in writing by sending written request to Millennium Health at 16981 Via Tazon, San Diego, CA 92127. Revoking this Authorization will prohibit further disclosure of my health information by Millennium Health; however, revoking this Authorization will not affect information disclosed by Millennium Health prior to the revocation.

5. I understand that once my health information has been disclosed, the recipient may further disclose this information and federal privacy laws may no longer protect the information from further disclosure.

6. **Unless I revoke it, this Authorization expires (ends) on the following date:**
____/____/_____. **A SPECIFIC DATE MUST BE FILLED IN*****
Month / Day / Year ****(End of litigation is not an acceptable expiration date)

7. I may obtain a copy of this Authorization to keep for my records.

Signature of Patient *or* Legal Representative (if applicable)	**Date**
Patient's Date of Birth	
Print Name of Patient *or* Legal Representative (if applicable)	Legal Representative's Relationship to Patient (if applicable)