I authorize Scheurer Health to release copies of Protected Health Information from the below marked facility(s):
Scheurer Primary Care: □ Caseville □ Elkton □ Sebewaing □ Pigeon □ Bad Axe
Scheurer Family Pharmacy: □ Pigeon □ Elkton □Caseville □ Sebewaing
□ Scheurer Health □ Scheurer Specialty Care □ Scheurer Health FastCare □ Scheurer Family Vision Center
□ Country Gardens

The records listed below are protected by Federal law. If you want this information included with this release, please initial only the items to be included.

_____Alcohol and/or drug abuse, mental health, psychological services, social services.
_____Information concerning Human Immunodeficiency Virus (HIV) test results, Acquired Immunodeficiency Disease (AIDS) or related diseases such as Communicable diseases and infections.

This authorization expires within (60) days from the date this authorization is signed. I may revoke this authorization at any time by notifying Scheurer Health- Health Information Management Services in writing and if I do, it will not have any effect on any actions taken before the revocation was received. There might be exceptions to revoke this authorization, please read your Notice of Privacy Practices to discover your revocation rights and exceptions to revocation. Treatment, payment, enrollment, or eligibility for benefits are not a condition of a signature on this authorization. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure. Redisclosed protected health information, once released as requested from the hospital, will no longer be protected by HIPAA (Health Information Portability Accountability Act) including paper, facsimiles, or electronic media. I understand mailing paper medical records through the U.S. Postal Service includes the risk of loss or theft of the documents. By signing below, I release Scheurer Network of any and all responsibilities regarding loss or theft of any mailed/received documents included in this request.

*Information is to be disclosed to: □ Myself ☒ Other: RECORDS DEPOSITION SERVICE, INC. P: 248.357.3330 PO BOX 5054, SOUTHFIELD, MI 48086-5054
(Name of person, Physician, Insurance Company, Attorney, etc.)

*WHAT INFORMATION: AS INDICATED ON THE ENCLOSED SUBPOENA OR REQUEST FOR INFORMATION * DATE OF SERVICE: _____/_____/_____

*I would like to receive the above information on the following format (check those that apply):
□ Encrypted electronic media (type of media) _____ □ Fax (____) _____--_____
□ Unencrypted electronic media _____ (initial agreeing to risks as explained on the back of the yellow portion of this form)
☒ Email REQUESTS@RECDEP.COM
□ Paper copies to hand carry (Release only to the person named in "disclosed to" area above)
□ Paper copies mailed to: _____
Street Address/PO Box City State Zip Code
□View on computer (**by appointment only,** write phone number below to set appointment)

*PATIENT NAME: (print) _____*DOB _____Phone (_____)_____--_____

_____
*Legally Authorized Signature * (Relationship) *Drivers License/ID Card * Today's Date

Signature of designee (if not patient)_____ Date _____

Witness signature _____ Date _____

* **This authorization is invalid if any of the starred (*) items are missing**

Phone 989-453-5235 **Fax 989-453-4455** **Email: Scheurer_HIMS@scheurer.org**

SCHEURER STAFF ONLY:
ROI log#: _____ MRN _____
Date Received: ___/____/____ Evident Account # _____ Copies were released on___/___/___ by _____

Scheurer Health

Form# 733
Revised: 05/06/2020

AUTHORIZATION FOR RELEASE OF PATIENT HEALTH INFORMATION

ORIGINAL: MEDICAL RECORDS
YELLOW: PATIENT