ST JOHN HEALTH PROVIDENCE

AUTHORIZATION FOR RELEASE OF INFORMATION

Patient's Name: _____

Patient's Address: _____ City _____ State: ____ Zip Code: _____

Social Security #: _____ Birth Date: _____

Date of Treatment: _____

I authorize Providence Hospital to release all information contained in my patient records, including as applicable:

- Information about human immunodeficiency virus (HIV), acquired immunodeficiency syndrome (syndrome), (AIDS) and AIDS related complex (ARC).
- Alcohol and drug abuse treatment information protracted under the regulations in 42 Code or Federal Regulations, Part 2.
- Mental Health treatment records, and psychological service and social services information including communications made by me to a social worker or psychologist.

To the individuals or organizations listed below, only under the conditions listed below:

1. Name and address of receiver of information:
   RECORDS DEPOSITION SERVICE, INC.
   PO BOX 5054, SOUTHFIELD, MI 48086-5054 P: 248.357.3330 F: 248.357.3337
   (Address)
2. Specific type of information to be disclosed: _____
3. The purpose and need for such disclosure: **FOR DISCOVERY BEFORE TRIAL**
4. This consent can be revoked at any time except to the extent that information has already been released or disclosed. Any authorization for the release or disclosure of drug and alcohol abuse records shall end when the purpose for the release has been achieved. This authorization will expire automatically when the purpose for the release or disclosure has been achieved or upon 90 days after the date below, whichever is later. _____

_____ _____
Patient's Signature Date

_____ _____
(And Parent or Guardian's Signature, where appropriate) Witness By