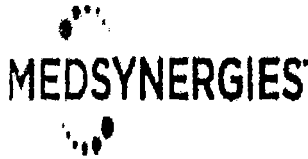

Clinic/Provider's name: ST. JOSEPH ORTHOPEDIC ASSOCIATES
Medical record number: ____________________

Patient: ______________________________

Date of birth: __________________________

Authorization for the Inspection, Use, Disclosure And Release of Health Information

I certify that I am the patient or legally authorized representative of the patient and I hereby request and authorize MedSynergies (MSI) to release the health information on the above named patient as follows:

Purpose of the Request/Authorization

- o Inspect health information
- o Obtain a copy of health information
- ☑ Release health information to the persons identified below

Health Information Requested/Authorized

- o Billing records
- o Discharge summary
- o Progress notes
- o Outpatient clinic visits
- o Operative report
- o Labs, x-rays, pathology, EKG, EEG, CT Scan
- o Doctor's orders
- o Nurse's notes
- o Photographs, video, digital/other images
- o Psychiatric/Psychological
- ☑ Other (Specify) PLEASE SEE THE ATTACHED SUBPOENA OR LETTER REQUEST

Identify the date(s) of the health information requested SEE SUBPOENA OR LETTER REQUEST

Disclosure Details

This disclosure is made at the request of:

- ☑ Patient or legally authorized representative
- o Other (Specify) ______________________________

This health information may be disclosed to

Name RECORDS DEPOSITION SERVICE, INC.
Address P.O. BOX 5054
City/State/Zip SOUTHFIELD / MICHIGAN / 48086-5054
P: 248-357-3330 F: 248-357-3337 E-MAIL: REQUESTS@RECDEP.COM

Time limit, Right to revoke, re-disclosure and treatment

MSI is hereby released from legal responsibility or liability for the disclosure of the records to the extent indicated and authorized herein. I also understand that I may revoke this authorization in writing at any time (except to the extent that action has been taken in relying on this authorization) by sending a written notice to MSI's Privacy Officer, 909 Hidden Ridge, Suite 300, Irving, Texas 75038, or by calling MSI's Privacy Officer at 972-791-1224.

Unless otherwise revoked, this authorization will expire 180 days from the date of my signature or as otherwise specified by an event related to the patient or the purpose of this disclosure as follows:________________________________

I understand treatment may not be conditioned on my completion of this authorization form.

I understand that this health information may no longer be protected by federal and state privacy laws once it is disclosed, and therefore, may be subject to re-disclosure by the recipient.

Date: ____________________ Signature ____

Patient or legally authorized representative

Time: ____________________

________________________ ____

Relationship to patient Printed name of patient or legally authorized representative

Identity Verification

Identity of requestor verified via: ____ Photo ID ___ Matching signature ___ Other (Specify)___ ____________