
4535 Dressler Rd. NW, Canton, OH 44718
1-855-687-0618 Fax (330) 492-8489

**AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION**
**45 CFR §164.508**

Federal and State law, including the Health Insurance Portability and Accountability Act ("HIPAA"), requires health care providers to protect your health information. US Acute Care Solutions ("USACS") provides billing and management services for affiliated or contracted healthcare providers, who provide Acute Care medical services. This form authorizes the release of your billing records and statements for treatment you received. If you need a copy of your medical record or chart, those must be obtained from the hospital's medical record department where you received treatment.

Print Patient Name:_____

**I authorize the release and disclosure of my Protected Health Information ("PHI") under the restrictions and conditions in this Authorization form.**

1. Person or persons, entity or entities who may disclose my Protected Health Information:
   - ☐ a. USACS and/or its employees or agents, and includes the treating USACS physician or other health care provider.
   - ☐ b. Specific person (specify): _____
2. The following PHI may be released or disclosed:
   - ☐ a. Billing and medical records for medical services received by me (check and complete only one):
     - ☐ Date of medical treatment for illness, injury, or accident on:_____ (date).
     - ☐ Dates of medical treatment for illness, injury or accident from: _____ (date) to: _____ (date).
     - ☐ At any and all times and dates treated.
   - ☐ b. Other (specify): _____
3. The PHI specified in this Authorization may be released and/or disclosed to the following individual(s) and/or organizations (such as carriers, insurance companies, lawyers, law firms, etc.): RECORDS DEPOSITION SERVICE, INC.
   PO BOX 5054, SOUTHFIELD, MI, 48086-5054 P:248-357-3330 F:248-357-3337

4. I am authorizing disclosure of my PHI for the following purpose(s):

   ☐ a. Assist in payment or reimbursement of my health care expenses.

   ☐ b. Assist in pursuing or defending a lawsuit, prosecution, or other legal proceeding.

   ☑ c. Other: PRE TRIAL DISCOVERY

   ☐ d. At my request. (Check this if you prefer not to give your reason for authorizing disclosure of your PHI.)

5. I understand that this Authorization may include disclosure of information relating to alcohol and drug abuse, mental health treatment (except psychotherapy notes), genetic testing information, and confidential AIDS/HIV related information. IF I INITIALED below, USACSf should NOT disclose this subject matter related information unless further authorization is obtained:

   Initials

   _____ (a) HIV/AIDS related information and/or records

   _____ (b) Mental health information and/or records (except psychotherapy notes)

   _____ (c) Genetic testing information and/or records

   _____ (d) Drug/alcohol diagnosis, treatment and referral information

6. I understand that if whoever receives my Protected Health Information (PHI) is not a health care provider or health plan covered by federal privacy regulations, the disclosed information may be redisclosed and is no longer protected by those regulations. I release any and all parties permitted to disclose my PHI by this Authorization, and their employers and staff, from all liability arising from the disclosure of my PHI under this Authorization.

7. I understand that I have the right to revoke this Authorization, in writing, at any time by sending written notice to: Privacy Officer, 4535 Dressler Road NW, Canton, OH 44718. I understand that a revocation is not effective to the extent that action has already been taken in reliance upon this Authorization.

8. I understand that I may refuse to sign this Authorization and that my refusal to sign will not affect my ability to obtain treatment, payment or my eligibility for benefits.

9. This Authorization will expire automatically in six (6) years, or earlier if one of the following occurs before the six years is up: (Leave both blank if you want the Authorization to be in force for the maximum of six years.)

   a. Specific date: _____ (must be less than six years from date signed).

   b. Specific event: _____ . (Example, a lawsuit is settled)

Print Patient's Name

Address of Patient:

Social Security No.:_____

Account No.:_____

Signature of Patient

Date Signed:_____

Print Name of Patient's Personal Representative/Guardian

Address of Personal Representative/Guardian:

Description of Representative's Authority to Act for the Patient:

- ☐ Parent
- ☐ Medical Power of attorney/representative
- ☐ Legal guardian
- ☐ Health care surrogate
- ☐ Other; specify _____

Signature of Personal Representative/Guardian

Date Signed:_____

## INSTRUCTIONS FOR COMPLETING THE HIPAA AUTHORIZATION FORM

Our Authorization Form has been designed to comply with requirements contained in the federal privacy regulations, known as HIPAA, concerning protected health information that went into effect on April 14,2003. (**See** 45 CFR 164.580(c))

The patient or the patient's personal representative must complete and sign the Authorization. While we do not provide legal advice and individual situations vary, personal representatives may include a patient's parents, spouse or adult children, as well as individuals who hold a power of attorney or who are responsible for handling a patient's estate.

**Please read each item of the Authorization carefully before completing any blank spaces.**

**Item No. 2:** Identify the date(s) of service and type of information to be released. Please note that while we own and maintain billing records concerning the medical care we provide, we do not own medical records. Medical records are owned and maintained by the facilities where we provide care. Authorizations for the release of medical records need to be directed to the Medical Records Department at the appropriate facility.

**Item No. 3:** Tell us the specific names of the individuals or organizations to whom we are authorized to release the information. (Ex: John Doe (spouse), Jane Doe (daughter), Allstate Auto Insurance, The ABC Law Firm, etc.).

**Item No. 4:** You need to tell us why you would like us to release the information. (Ex: to get a claim paid by auto insurance, my spouse takes care of my medical bills, etc.).

**Item No. 5:** **IMPORTANT** - If you do not want us to disclose any of the medical conditions listed in Section 5, you must initial each applicable condition. If initialed, we will obtain additional authorization before releasing any of these conditions. If there are no initials, then you are authorizing us to release the conditions, when necessary.

**Item No. 9:** Please note that this release will expire six years from the date that it is signed by the patient or the patient's personal representative UNLESS an earlier date is placed in the blank.

**Please remember to sign and date the authorization.** The patient or the patient's personal representative must complete and sign this section.

If you have any questions filling out this authorization, please call our Patient Services Department at 855-687-0618.
Monday – Thursday 8 AM to 8 PM Eastern time
Friday 8 AM to 5 PM Eastern time

Effective 04/14/03
Revised 11/19/13