Faith Palliative Care Authorization for
Release of Information
Other than for Treatment, Payment, or Operations

Name of Client: ______________________________ Date: ______________

1. **Authorization**. I hereby authorize the use and disclosure of my health information as indicated below. I understand that this release is voluntary.

2. **Party Who May Release Information to be Disclosed**. I hereby authorize the release by Faith Palliative Care the information checked and/or listed below for the time period beginning on ______________________ and ending on ______________________:

- [ ] Complete health care record(s)
- [ ] History & Physical Examination
- [ ] Minimum Data Set
- [ ] Laboratory Reports
- [ ] Medical / Treatment Records
- [ ] Pathology Reports
- [ ] X-Ray Reports
- [ ] Transcribed Reports
- [ ] Nurses' Notes
- [ ] Discharge Summary
- [ ] Progress Notes
- [ ] Care Plans
- [ ] Dental Records
- [ ] Photographs, Video Tapes, Digital, or other images
- [ ] Billing Statements
- [ ] Emergency Care Records
- [ ] Consultant Reports
- [ ] Other: ______________________________
- [ ] Other: ______________________________

3. **Party or Parties To Whom Information May Be Released**. The information checked and/or listed above is to be released to and discussed with this or these recipient(s) (Name, Address and Phone Number):

Records Deposition Service
29100 Northwestern Hwy., Ste. 300
Southfield, MI 48034
F (248) 357-3337 E requests@recdep.com

4. **Purpose of Request**. I understand that I am not required to disclose the purpose of my request. If I do not wish to do so, I will check the box that says "At my request." If I wish to provide more detailed information, I may do so. The purpose of this request is:

❑ At my request. (Note: this is a sufficient description of the purpose when an individual initiates the Authorization and does not, or elects not to, provide a statement of the purpose.)
☑ Description of request: pretrial discovery

5. **Expiration of Request**. Unless otherwise revoked by me, I understand that this Authorization will expire on (choose one):

❑ On the following date: ______________________
❑ Upon the following event: ______________________

6. **Conditioning of Treatment, Payment, Enrollment, or Eligibility on Signing**.

Holland Home may not condition treatment, payment, enrollment in a health plan or eligibility for benefits on whether the Client or his or her representative signs this Authorization.

7. **Inspection and Copying**. I understand that I may inspect and copy any information used or disclosed under this Authorization. I understand that I will be charged for any copying services in accordance with applicable law.

8. **Format of Requested Documents**. I request that the documents be released to the recipient(s) in the following format(s):

- ☐ Physical review of the records within twenty-four hours of Faith Palliative Care receipt of this request (excluding weekends and holidays).
- ☐ Hard copies of the records.
- ☑ Electronic copies of the records if they exist or if Faith Palliative Care has the capability to make these.

9. **Release**. I hereby release the facility, its employees, officers, and health care professionals from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized in this Authorization.

10. **Revocation**. I understand that I may revoke this Authorization at any time. This revocation will be in a signed writing delivered to Faith Palliative Care. I further understand that the revocation will not take effect until Faith Palliative Care receives it and, even then, will be ineffective to the extent that Faith Palliative Care has already disclosed the information, otherwise relied on this Authorization, or to the extent that use, or disclosure is otherwise permitted or required by law.

11. **Re-disclosure**. I also understand that if the individual or organization authorized to receive this information is not required to comply with current privacy regulations, my health information may be re-disclosed to others and no longer protected by current state and federal privacy regulations.

12. **Authorization Requested by Holland Home**. If Faith Palliative Care is seeking this Authorization from the Client for a use or disclosure of the information, Faith Palliative Care will provide the Client with a copy of the signed Authorization.

13. **Authority of Representative**. **[Complete only when applicable.]** I am not the Client whose information is to be disclosed. However, I have legal authority to act on behalf of the Client as his or her:

☐ Legal Guardian	☐ Patient Advocate Designee
☐ Parent of Minor	☐ Personal Representative

14. **Full Authorization.** I understand and acknowledge that this Authorization extends to all or any part of the records being requested, which may include treatment for physical and mental illness (except for psychotherapy notes which must be requested by separate authorization); alcohol/drug abuse, and/or HIV/AIDS test results or diagnosis and treatment. Initial Here: ___

A description of my authority to act for the Client is as follows:____

____.

Date:__________________ Signature of Client:______________________________

Printed Name of Client:______________________

Date:__________________ Signature of Representative:______________________

Printed Name of Representative:________________

Relationship to Client:__________________

Date:__________________ Signature of Witness:____________________________

Printed Name of Witness:__________________________

cc: Person making request
Client's medical record