



Authorization for Release of Information

NOTE: COMPLETE ALL FIELDS TO ENSURE YOUR REQUEST CAN BE PROCESSED

Office Location: _____

I AUTHORIZE AND REQUEST the release of the specific information below for the patient listed here:

PATIENT NAME: _____

LAST FIRST MI MAIDEN OR OTHER NAME DATE OF BIRTH SS#

AUTHORIZED BY: (Patient, Parent or legal guardian) AND; I am authorized to make this disclosure:

Name: _____ Date of Birth: _____ Phone# _____ Relationship: _____

Address: _____

RELEASE FROM CURRENT PRACTICE (WHERE YOUR RECORDS ARE COMING FROM):

Name: _____

Address: _____

RELEASE RECORDS TO:

Name: Records Deposition Service

Address: P.O. Box 5054, Southfield, MI 48086-5054 F (248) 357-3337 E requests@recdep.com

INFORMATION TO BE RELEASED: (Initial Below)

Dates of service: ____/____/____ through ____/____/____

- _____ Specifically my entire medical record including, Substance Abuse, Mental Health, HIV related testing;
- _____ Specifically my entire medical record excluding, Substance Abuse, Mental Health, HIV related testing;
- _____ Other: All relevant medical, inpatient, and diagnostic testing records or Specifically only _____

PURPOSE OF DISCLOSURE:

- Relocating out of area Changing doctor in area Specialist Consultation/second opinion
- Transfer from pediatric to adult doctor Legal School Insurance Change (Non-par)
- Workers Compensation Medical Care

1. I understand that this authorization will expire 60 days **after I have signed the form.**
2. I understand that I may revoke this authorization at any time by notifying the providing organization in writing, and it will be effective on the date notified except to the extent action has already been taken in reliance upon it. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by Federal privacy regulations.
3. I understand signing this form is an option, my health care and payment for my health care will not be affected if I do not sign.
4. I understand that in compliance with the State of Michigan laws pertaining to record copies, I may be charged a reasonable cost based fee of \$ _____. I may also be charged for each x-ray copy \$15 per sheet. There is no charge for medical records if copies are sent to facilities for Specialist care, school purposes, insurance billing, or for Worker's Compensation.

SIGNATURE OF PATIENT DATE OR PARENT/LEGAL GUARDIAN/AUTHORIZED PERSON DATE

RECORDS RECEIVED BY DATE RELATIONSHIP TO PATIENT

INTERNAL USE

PRESENTED ID: _____	VERIFIED BY: _____	PROOF OF LEGAL GUARDIANSHIP: _____
PROVIDER REVIEWED: _____	DATE: _____	DATE REQUEST FILLED: _____ BY: _____
FEE COLLECTED: _____	WRITTEN REQUEST TO REVOKE (ATTACH) PROCESSED BY: _____	EFF DATE: _____