___ Knowledge Health Medical Services, PC
___ Preventive Medicine Associates, PC

AUTHORIZATION FOR RELEASE OF PROTECTED OR PRIVILEGED HEALTH INFORMATION

Please print all information clearly so we can timely process your request.

A. PATIENT INFORMATION

PATIENT NAME:

PATIENT DATE OF BIRTH:

PATIENT ADDRESS:

PATIENT TELEPHONE NUMBER: ( )

PATIENT ADDRESS:

PATIENT EMAIL:

PATIENT EMAIL:

PATIENT CASE # (if known):

B. PERMISSION TO SHARE I give permission to share my medical information as follows:

Dates of Service:

☐ All ☐ Specific: _____

PURPOSE for which records are needed (check the appropriate box)

☐ Medical Care

☐ Personal*

☐ Insurance*

☐ School

☒ Litigation / Legal Claim *

☐ Other* (please specify) _____

* Copy fees may apply

TO: (Where would you like the information sent:

Name of Person:

Name of Organization:
Records Deposition Service

Address:
P.O. Box 5054, Southfield, MI 48086-5054

Telephone Number: (248) 357-3330

SEND BY:

☒ Secure email to: requests@recdep.com

☐ Paper copy by Mail

☒ Fax to: (248) 357-3337

☐ Other:

C. INFORMATION TO BE RELEASED (Please check all that apply)

☐ Medical Record Abstract (History & physical, test results, discharge summary) (specific dates of service?) _____

☐ Clinic Visit Notes (specific dates of service?) _____

☐ Medical Chat (your private chat with the clinician during this telehealth visit)_____

☐ Lab Reports (specific dates of service?) _____

☐ Pathology Reports (specific dates of service?) _____

☐ Radiology Reports (specific dates of service?) _____

☐ Photographs: (specific dates of service?) _____

☐ Billing Records: (specific dates of service?) _____

☐ Other: (specific dates of service?) _____

D. Please check YES if you give permission to release the following information if it is in your records:

☐ Yes	HIV Test Results
☐ Yes	Genetic Screening test results
☐ Yes	Mental Health, incl. details of diagnosis and treatment provided by a physician, psychologist, mental health clinical nurse specialist, licensed mental health clinician. (Your permission may not be required to release mental health information for payment purposes.)
☐ Yes	Details of Domestic Violence Victim's Counseling
☐ Yes	Details of Sexual Assault Counseling
☐ Yes	Records showing access to reproductive health (if required by state law)
☐ Yes	Records showing access to gender affirming care (if required by state law)
☐ Yes	Treatment for sexually transmitted diseases (Alabama)
☐ Yes	Treatment for Substance Use Disorder

E. I understand and agree that:

- Knowledge Health Medical Services, PC (the "Practice") cannot control how the recipient uses or shares the information, and laws protecting the confidentiality of records at the Practice may not protect this information once it is released.
- This authorization is voluntary. My treatment will not be affected by whether I sign this form.
- I may cancel this authorization at any time by submitting a written request to the Practice, except:
  - if the Practice has already relied on it (Once your information is released, it cannot be retrieved)
  - if I signed this authorization as a condition of obtaining insurance, other laws may provide the insurer with a right to contest a claim under my policy
- This authorization will automatically expire on _____ (if left blank, 6 months from the date signed)
- I understand that if the Practice has any records from other providers, these will not be released unless I specifically ask for them under "Other" in section C. Please include entity name, provider, and dates of service.
- My questions about this authorization form have been answered.

F. PATIENT SIGNATURE: DATE:

PRINT NAME:

If the patient is a minor, or is not competent to give consent, the signature of a parent, guardian, or other legal representative is required.

Signature of Legal Representative: Date:

Print Name: