

Authorization for Use or Disclosure of Protected Health Information

COMPLETE ALL SECTIONS, DATE, AND SIGN

I, _____, authorize the disclosure of information from my medical record.
(Name of Patient)

Birthdate: _____ **SSN (Last 4 digits):** XXX-XX-_____

II.

The information is to be disclosed by:	And is to be provided/sent to:
<i>NAME OF FACILITY</i>	<i>NAME OF PERSON/ORGANIZATION/FACILITY</i> Records Deposition Service
<i>ADDRESS</i>	<i>ADDRESS</i> P.O. Box 5054
<i>CITY, STATE, ZIP</i>	<i>CITY, STATE, ZIP</i> Southfield, MI 48086-5054

III. **Purpose or need for this disclosure is:**

- Continued Treatment Attorney School Research
 Personal Use Insurance Disability Other _____

IV. **Information to be disclosed from my medical record: (Check appropriate box(es))**

- Only information related to (specify) _____
 Only for dates of service from _____ to _____
 Other (specify) (ex: radiology, billing, etc.) _____
 Entire Record

V. **If you would like any of the following sensitive information disclosed, check the applicable box(es) below:**

- Alcohol/Drug Abuse Treatment/Referral Mental Health (*Other than Psychotherapy Notes*)
 Sexually Transmitted Diseases Genetic Testing
 HIV/AIDS Testing & Treatment Sexual & Reproductive Health

VI. I understand that by signing this authorization, my Treatment, Payment and enrollment in a health plan or eligibility for benefits will not be conditioned upon my authorization of this disclosure.

VII. I understand that the information disclosed may be subject to redisclosure by the person or entity receiving it and would then no longer be protected by federal privacy regulations.

VIII. I may revoke this authorization by notifying _____ in writing of my desire to revoke it. However, I understand that any actions already taken based on this authorization cannot be reversed and my revocation will not affect those actions.

IX. This authorization expires on _____, 20____, OR upon the following event:

 If no date or event is specified, the authorization will automatically expire one (1) year from the signature date.

 SIGNATURE OF PATIENT

 DATE

 SIGNATURE OF PERSONAL REPRESENTATIVE & RELATIONSHIP TO PATIENT

 DATE

 SIGNATURE OF WITNESS (If signature of patient is a thumbprint or mark)

 DATE