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P.O. Box 5054
Southfield, MI 48086-5054
(248) 357-3330

www.recdep.com

ESSENTIAL AUTHORIZATIONS PACKET

Includes:

HIPAA Compliant Medical Authorization
HIPAA Compliant Medical Authorization with Notary
General Authorization
Social Security Administration (Benefits) - Original Ink Signature
Social Security Administration (Earnings)
IRS (Tax Return)
MI Department of Treasury
MI Department of Health and Human Services
BCBS of Michigan
Henry Ford Health System

Please include completed/signed copies with requests for records.
All except Social Security Administration may be sent to RDS via
requests@recdep.com
f: 248.357.3337

If you need additional forms (including 500+ facility-specific authorizations), please visit recdep.com/authorizations or contact us if you have any questions.

Thank you!

RECORDS DEPOSITION SERVICE
PO BOX 5054 • SOUTHFIELD, MI 48086-5054
P: 248.357.3330 • F: 248.357.3337 • INFO@RECDEP.COM

MEDICAL AUTHORIZATION

I, _____ _____ _____
(Patient Name) **(Date of Birth)** **(Social Security Number)**

hereby authorize

_____
(Hospital/Health Care Provider/Doctor Name)

its Director or Designee, or Medical Record Department, to release information contained in my patient records, including alcohol and drug abuse records protected under the regulations in Code 42 of Federal Regulations, Part 2, if any; Psychological Services Records, if any; Social Services Records, if any; Psychiatric Records, if any, including communications made by me to a Social Worker, Psychologist or Psychiatrist, if any; Human Immunodeficiency Virus (HIV), Acquired Immunodeficiency Syndrome (AIDS), and AIDS Related Complex (ARC) Records, if any; Communicable Disease and Serious Communicable Disease and Infections, Venereal Diseases, Tuberculosis, Hepatitis B, Sickle Cell Anemia Records, if any, to:

RECORDS DEPOSITION SERVICE, INC., PO Box 5054, Southfield, MI 48086-5054

Note: Disclosure is to be made to Records Deposition Service, Inc. only. All other disclosures are unauthorized!

1. Information to be disclosed: **Please see enclosed Subpoena or Letter Request for information to be disclosed.**
2. The purpose and need for such disclosure: **For Discovery Before Trial**
3. This Authorization is subject to revocation at any time by contacting Records Deposition Service, Inc. in writing. I understand that the revocation will not apply to information that has already been released in response to this Authorization.
4. Without expressed revocation, this authorization expires on the date set forth: _____ or the following event: Once information is disclosed, no further information can be disclosed pursuant to this authorization.
5. I understand the provider may not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this form.
6. A photocopy of this document shall be considered valid as if the original were offered. This Authorization is only valid if submitted by Records Deposition Service, Inc. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by Federal or State Law. Records Deposition Service, Inc. is not liable for damages as the result of an unauthorized disclosure.

_____ _____ _____
Signature of Patient **Printed Name** **Date Signed**

_____ _____ _____
Signature of Parent/Guardian/Personal Representative **Printed Name** **Date Signed**

_____
Relationship to Patient

RECORDS DEPOSITION SERVICE
PO BOX 5054 • SOUTHFIELD, MI 48086-5054
P: 248.357.3330 • F: 248.357.3337 • INFO@RECDEP.COM

MEDICAL AUTHORIZATION

I, _____ _____ _____
(Patient Name) **(Date of Birth)** **(Social Security Number)**

hereby authorize

_____
(Hospital/Health Care Provider/Doctor Name)

its Director or Designee, or Medical Record Department, to release information contained in my patient records, including alcohol and drug abuse records protected under the regulations in Code 42 of Federal Regulations, Part 2, if any; Psychological Services Records, if any; Social Services Records, if any; Psychiatric Records, if any, including communications made by me to a Social Worker, Psychologist or Psychiatrist, if any; Human Immunodeficiency Virus (HIV), Acquired Immunodeficiency Syndrome (AIDS), and AIDS Related Complex (ARC) Records, if any; Communicable Disease and Serious Communicable Disease and Infections, Venereal Diseases, Tuberculosis, Hepatitis B, Sickle Cell Anemia Records, if any, to:

RECORDS DEPOSITION SERVICE, INC., PO BOX 5054, SOUTHFIELD, MI 48086-5054

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_____ _____ _____
Signature of Patient **Printed Name** **Date Signed**

_____ _____ _____
Signature of Parent/Guardian/Personal Representative **Printed Name** **Date Signed**

_____
Relationship to Patient

Notary: Subscribed and Sworn before me this _____ Day of _____, 20 ____.

_____, Notary Public _____ County
Signature

_____ My Commission expires: _____
Printed Name

RECORDS DEPOSITION SERVICE
PO BOX 5054 • SOUTHFIELD, MI 48086-5054
P: 248.357.3330 • F: 248.357.3337 • INFO@RECDEP.COM

GENERAL AUTHORIZATION

I, _____ _____ _____
(Printed Name) **(Date of Birth)** **(Social Security Number)**

_____
(Address)

hereby authorize

_____
(Deponent/Custodian of Records)

to release any and all information which may be requested regarding myself and to allow them or any person appointed by them to examine or photocopy any records of me or records which the aforementioned Deponent/Custodian of Records may have contained in my file to:

RECORDS DEPOSITION SERVICE, INC., PO Box 5054, Southfield, MI 48086-5054

Note: Disclosure is to be made to Records Deposition Service, Inc. only. All other disclosures are unauthorized!

1. Information to be disclosed: **Please see enclosed Subpoena or Letter Request for information to be disclosed.**
2. The purpose and need for such disclosure: **For Discovery Before Trial**
3. This Authorization is subject to revocation at any time by contacting Records Deposition Service, Inc. in writing. I understand that the revocation will not apply to information that has already been released in response to this Authorization.
4. Without expressed revocation, this Authorization expires on the date set forth below or for the following specified reason: Once information is disclosed, no further information can be disclosed pursuant to this authorization.

   Or date: _____

   or event: _____
5. A photocopy of this document shall be considered valid as if the original were offered. This Authorization is only valid if submitted by Records Deposition Service, Inc. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by Federal or State Law. Records Deposition Service, Inc. is not liable for damages as the result of an unauthorized disclosure.

_____ _____ _____
Signature **Printed Name** **Date Signed**

Consent for Release of Information

You must complete all required fields. We will not honor your request unless all required fields are completed. *(*Signifies a required field. **These are not mandatory fields for the consent form to be acceptable. Please complete these fields in case we need to contact you about the consent form*).

TO: Social Security Administration

***Full Name**	***Date of Birth (MM/DD/YYYY)**	***Full Social Security Number**

I authorize the Social Security Administration to release information or records about me to:

***NAME OF PERSON OR ORGANIZATION:**

Records Deposition Service
p 248-357-3330 f 248-357-3337
email requests@recdep.com

***ADDRESS OF PERSON OR ORGANIZATION:**
**** PHONE NUMBER OF PERSON OR ORGANIZATION:**

29100 Northwestern Hwy., Ste. 300
Southfield, MI 48034

***I want this information released because:**
We may charge a fee to release information for non-program purposes.

discovery before trial

***Please release the following information selected from the list below:**
Check at least one box. If requesting medical records, do not check both boxes 7 and 8. We will not disclose records unless you include specific date ranges where applicable.

1. ☐ Verification of Social Security Number
2. ☑ Current monthly Social Security benefit amount
3. ☑ Current monthly Supplemental Security Income payment amount
4. ☐ Social Security benefit amounts from date _____ to date _____
5. ☐ Supplemental Security Income payment amounts from date _____ to date _____
6. ☐ Medicare entitlement from date _____ to date _____
7. ☐ Medical records from date _____ to date _____
8. ☑ Complete medical records
9. ☑ Other Social Security record(s) (We will not honor a request for "any and all records" or "the entire file." You must specify which records you are seeking. For example, award/denial notices, benefit applications, appeals)

applications, determinations, appeals, awards, denial notices

I am the individual, to whom the requested information or record applies, or the parent or legal guardian of a minor, or the legal guardian of a legally incompetent adult. I declare under penalty of perjury (28 CFR § 1746) that I have examined all the information on this form and it is true and correct to the best of my knowledge. I understand that anyone who knowingly or willfully seeks or obtains access to records about another person under false pretenses is punishable by a fine of up to $5,000.

***Signature:** _____ ***Date:** _____

****Address:** _____ ****Daytime Phone:** _____

****Relationship (if not the subject of the record):** _____ ****Daytime Phone:** _____

Witnesses must sign this form ONLY if the above signature is by mark (X). If signed by mark (X), two witnesses to the signing who know the signee must sign below and provide their full addresses. Please print the signee's name next to the mark (X) on the signature line above.

1.Signature of witness	2.Signature of witness
Address (Number and street,City,State, and ZIP Code)	Address (Number and street,City,State, and ZIP Code)

REQUEST FOR SOCIAL SECURITY EARNING INFORMATION

1. Provide your name as it appears on your most recent Social Security card or the name of the individual whose earnings you are requesting.

First Name: Middle Initial:

Last Name:

Social Security Number (SSN) One SSN per request

Date of Birth: Date of Death:

Other Name(s) Used
Maiden Name

2. What kind of earnings information do you need? (Choose **ONE** of the following types of earnings or SSA must return this request.)

[X] **Itemized Statement of Earnings $61.00**
(Includes the names and addresses of employers)
If you check this box, tell us why you need this information below.

Year(s) Requested: to
Year(s) Requested: to

[X] Check this box if you want the earnings information **CERTIFIED** for an additional $35.00 fee.

[ ] **Certified Yearly Totals of Earnings $35.00**
(Does not include the names and addresses of employers)Yearly earnings totals are FREE to the public if you do not require certification. To obtain FREE yearly totals of earnings, visit our website at www.ssa.gov/myaccount.

Year(s) Requested: to
Year(s) Requested: to

3. If you would like this information **sent to someone else**, please fill in the information below.
I authorize the Social Security Administration to release the earnings information to:

Name Records Deposition Service P (248) 357-3330 F (248) 357-3337 E requests@recdep.com

Address P.O. Box 5054 State MI

City Southfield ZIP Code 48086-5054

4. I am the individual to whom the record pertains (or a person authorized to sign on behalf of that individual). I declare under penalty of perjury that I have examined all the information on this form, and on any accompanying statements or forms, and it is true and correct to the best of my knowledge.

Signature AND Printed Name of Individual or Legal Guardian

SSA must receive this form within 120 days from the date signed

Date

Relationship (if applicable, you must attach proof) Daytime Phone:

Address State

City ZIP Code

Witnesses must sign this form ONLY if the above signature is by marked (X). If signed by mark (X), two witnesses to the signing who know the signee must sign below and provide their full addresses. Please print the signee's name next to the mark (X) on the signature line above.

1. Signature of Witness	2. Signature of Witness
Address *(Number and Street, City, State and ZIP Code)*	Address *(Number and Street, City, State and ZIP Code)*

Form **4506**

(September 2024)

Department of the Treasury
Internal Revenue Service

Request for Copy of Tax Return

▶ **Do not sign this form unless all applicable lines have been completed.**
▶ **Request may be rejected if the form is incomplete or illegible.**
▶ **For more information about Form 4506, visit *www.irs.gov/form4506*.**

OMB No. 1545-0429

Tip: Get faster service: Online at www.irs.gov, **Get Your Tax Record** (Get Transcript) or by calling **1-800-908-9946** for specialized assistance. We have teams available to assist. **Note:** Taxpayers may register to use Get Transcript to view, print, or download the following transcript types: **Tax Return Transcript** (shows most line items including Adjusted Gross Income (AGI) from your original Form 1040-series tax return as filed, along with any forms and schedules), **Tax Account Transcript** (shows basic data such as return type, marital status, AGI, taxable income and all payment types), **Record of Account Transcript** (combines the tax return and tax account transcripts into one complete transcript), **Wage and Income Transcript** (shows data from information returns we receive such as Forms W-2, 1099, 1098 and Form 5498), and **Verification of Non-filing Letter** (provides proof that the IRS has no record of a filed Form 1040-series tax return for the year you request).

1a Name shown on tax return. If a joint return, enter the name shown first.	**1b First social security number on tax return, individual taxpayer identification number, or employer identification number (see instructions)**
2a If a joint return, enter spouse's name shown on tax return.	**2b Second social security number or individual taxpayer identification number if joint tax return**

3 Current name, address (including apt., room, or suite no.), city, state, and ZIP code (see instructions).

4 Previous address shown on the last return filed if different from line 3 (see instructions).

5 If the tax return is to be mailed to a third party (such as a mortgage company), enter the third party's name, address, and telephone number.
Records Deposition Service, PO Box 5054, Southfield, MI 48086-5054
(248) 357-3330

Caution: If the tax return is being sent to the third party, ensure that lines 5 through 7 are completed before signing. (see instructions).

6 **Tax return requested.** Form 1040, 1120, 941, etc. and all attachments as originally submitted to the IRS, including Form(s) W-2, schedules, or amended returns. Copies of Forms 1040, 1040A, and 1040EZ are generally available for 7 years from filing before they are destroyed by law. Other returns may be available for a longer period of time. Enter only one return number. If you need more than one type of return, you must complete another Form 4506. ▶ 1040

Note: If the copies must be certified for court or administrative proceedings, check here . . . . . ☒

7 **Year or period requested.** Enter the ending date of the tax year or period using the mm/dd/yyyy format (see instructions).
____/____/____ ____/____/____ ____/____/____ ____/____/____
____/____/____ ____/____/____ ____/____/____ ____/____/____

8	**Fee.** There is a $30 fee for each return requested. **Full payment must be included with your request or it will be rejected. Make your check or money order payable to "United States Treasury." Enter your SSN, ITIN, or EIN and "Form 4506 request" on your check or money order**	
a	Cost for each return	$
b	Number of returns requested on line 7	
c	Total cost. Multiply line 8a by line 8b	$

9 If we cannot find the tax return, we will refund the fee. If the refund should go to the third party listed on line 5, check here . . . . . ☒

Caution: Do not sign this form unless all applicable lines have been complete

Signature of taxpayer(s). I declare that I am either the taxpayer whose name is shown on line 1a or 2a, or a person authorized to obtain the tax return requested. If the request applies to a joint return, at least one spouse must sign. If signed by a corporate officer, 1 percent or more shareholder, partner, managing member, guardian, tax matters partner, executor, receiver, administrator, trustee, or party other than the taxpayer, I certify that I have the authority to execute Form 4506 on behalf of the taxpayer. **Note:** This form must be received by IRS within 120 days of the signature date.

☒ **Signatory attests that he/she has read the attestation clause and upon so reading declares that he/she has the authority to sign the Form 4506. See instructions**

Phone number of taxpayer on line 1a or 2a

Sign Here

▶ **Signature** (see instructions) | Date

▶ Print/Type name | **Title** (if line 1a above is a corporation, partnership, estate, or trust)

▶ **Spouse's signature** | Date

▶ Print/Type name

Michigan Department of Treasury
4095 (Rev. 06-23)

Issued under authority of Public Act 122 of 1941, MCL 205.1.

Request and Consent for Disclosure of Michigan Tax Return Information

The Revenue Act, Public Act 122 of 1941, MCL 205.28(1)(f), makes all information acquired in administering taxes confidential. The Michigan Department of Treasury recoups cost for preparing copies of tax returns or tax return information requested by authorized third parties. Taxpayers may receive copies of their personal tax returns at no charge. The current fee schedule is listed below (see Part 3).

PART 1: TAXPAYER INFORMATION

Enter the name of the individual or business, address and account number for which the tax information is being requested.

Taxpayer Last Name	First Name	MI	Social Security Number or FEIN	Telephone Number
Secondary Taxpayer Last Name	**First Name**	**MI**	**Social Security Number or FEIN**	**Telephone Number**

Address (Street)	City	State	ZIP Code	Email Address

Tax Type

☐ Income Tax ☐ SBT ☐ MBT ☐ CIT ☐ SUW ☐ Other _____

Tax Year(s)	Tax Forms
	1040

PART 2: AUTHORIZATION

I authorize the State of Michigan, Department of Treasury to furnish tax returns and/or tax return information specified in Part 1 to the appointee listed below. I understand that once the tax returns are furnished, the appointee is solely responsible for the privacy and security of the tax return information. **This authorization expires in six months and is not a substitute for a formal Form 151, *Authorized Representative Declaration.***

Appointee Name	Email Address	Telephone Number	
Records Deposition Service	requests@recdep.com	(248) 357-3330	
Address (Street)	**City**	**State**	**ZIP Code**
P.O. Box 5054	Southfield	MI	48086-5054
Signature of Taxpayer OR Legal Representative		**Date**	

☑ Check this box if you prefer to have your request emailed back.

PART 3: FEE SCHEDULE

Authorized third parties must pay the fee described here. Payment for tax return information must accompany the request. Make checks payable to the State of Michigan and write index code # 19182 on the check. * Large requests will be assessed differently.

First Year	$ 5.00	$5.00
Additional Year(s)	$ 3.00 X _____	
	FEE TOTAL	

Please allow 60 days for processing your request.
The Disclosure Unit will only provide records once. Records will not be resent without submitting a new 4095 form and fee.
You must submit your request with payment to the following address, "Michigan Department of Treasury, Disclosure Unit does not issue invoices. Please wait 30 days from mailing to check the status of request.

Send this form to:
Michigan Department of Treasury
Privacy and Security, Disclosure Unit
P.O. Box 30832
Lansing, MI 48909
Email: **Treas_Disclosure@michigan.gov**
Allow 60 days to process your request.

Treasury Use Only

1. ☐ The attached information is furnished for tax year(s) _____
2. ☐ No record of filing a return for tax year(s) _____
3. ☐ Other _____
4. ☐ See attached 4374 form for additional information needed

Disclosure Unit Approval Certification	Date Completed

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Directions: Type or Print all requested information, with exception of signatures on Page 2.

Individual's Name (Beneficiary, Recipient, Patient, Consumer, etc.)			**Individual's ID Number** (Medicaid, SSN, Other)
Street Address			**Individual's Date of Birth**
City	**State**	**ZIP**	**Phone**

I authorize the Michigan Department of Health and Human Services (MDHHS) to disclose the above-named individual's health information as described below. (Identify type and amount of information, including dates where appropriate.)

I understand that this information may include, when applicable, information relating to sexually transmitted disease, Human Immunodeficiency Virus (HIV Infection, Acquired Immune Deficiency Syndrome or AIDS Related Complex) and any other communicable disease. It may also include information about behavioral or mental health services, and referral and/or treatment for alcohol and drug abuse (as permitted by MCL 330.1748, P.A. 258 of 1974 and 42 CFR Part 2).

This information may be disclosed to and used by the following person or organization:

	RECORDS DEPOSITION SERVICE, INC.
(Person/Individual's Name)	(Organization Name)

Name of Person/Organization authorized to receive the protected health information.

PO BOX 5054
Street Address

SOUTHFIELD, MI, 48086-5054
City, State, ZIP

248-357-3330	248-357-3337
Phone Number	Fax Number

This disclosure and use is for the following purpose(s):* See Note below.

PRE TRIAL DISCOVERY

(* Note: The statement "at the request of the individual" is sufficient when the individual initiates an Authorization and does not, or chooses not to, state the purpose.)

I understand that if I give permission, I have the right to change my mind and **revoke** it. This must be in writing to the Facility or MDHHS Program that maintains the individual's records that I authorized on Page 1 of this form. I also understand that any uses or disclosures already made with my permission cannot be taken back.

If this authorization is needed as a condition to obtain health care coverage and I revoke it, then I understand that the above person/organization who would have received the information may have the right to contest health care coverage claims.

Unless otherwise revoked, this authorization will expire on the following date, event or condition. (If I fail to specify an expiration date, event or condition, this authorization will expire one year from the signature date.)

Date, Event or Condition

I understand that authorizing the disclosure of this health information is voluntary. I also understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment for services, or eligibility for benefits unless the information is necessary to demonstrate that I meet eligibility or enrollment criteria.

By signing this Authorization, I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal privacy rules. I further understand I may request a copy of this signed Authorization.

Legal Representative's Name (If applicable)	**Legal Representative's Relationship to Individual** (A letter of authority may be requested.)
Signature of Individual or Legal Representative	**Date**
Signature of Witness	**Date**

MDHHS Use Only

This authorization was revoked:

Signature **Date**

AUTHORITY: This form is acceptable to the Michigan Department of Health and Human Services as compliant with HIPAA privacy regulations, 45CFR Parts 160 and 164 as modified August 14, 2002.

COMPLETION: Is Voluntary, but required if disclosure is requested.

The Michigan Department of Health and Human Services is an equal opportunity employer, services and programs provider.

Michigan Department of Treasury
4095 (Rev. 06-23)

Issued under authority of Public Act 122 of 1941, MCL 205.1.

Request and Consent for Disclosure of Michigan Tax Return Information

The Revenue Act, Public Act 122 of 1941, MCL 205.28(1)(f), makes all information acquired in administering taxes confidential. The Michigan Department of Treasury recoups cost for preparing copies of tax returns or tax return information requested by authorized third parties. Taxpayers may receive copies of their personal tax returns at no charge. The current fee schedule is listed below (see Part 3).

PART 1: TAXPAYER INFORMATION

Enter the name of the individual or business, address and account number for which the tax information is being requested.

Taxpayer Last Name	First Name	MI	Social Security Number or FEIN	Telephone Number
Secondary Taxpayer Last Name	**First Name**	**MI**	**Social Security Number or FEIN**	**Telephone Number**

Address (Street)	City	State	ZIP Code	Email Address

Tax Type

☐ Income Tax ☐ SBT ☐ MBT ☐ CIT ☐ SUW ☐ Other _____

Tax Year(s)	Tax Forms
	1040

PART 2: AUTHORIZATION

I authorize the State of Michigan, Department of Treasury to furnish tax returns and/or tax return information specified in Part 1 to the appointee listed below. I understand that once the tax returns are furnished, the appointee is solely responsible for the privacy and security of the tax return information. **This authorization expires in six months and is not a substitute for a formal Form 151, *Authorized Representative Declaration.***

Appointee Name	Email Address	Telephone Number	
Records Deposition Service	requests@recdep.com	(248) 357-3330	
Address (Street)	**City**	**State**	**ZIP Code**
P.O. Box 5054	Southfield	MI	48086-5054
Signature of Taxpayer OR Legal Representative		**Date**	

☑ Check this box if you prefer to have your request emailed back.

PART 3: FEE SCHEDULE

Authorized third parties must pay the fee described here. Payment for tax return information must accompany the request. Make checks payable to the State of Michigan and write index code # 19182 on the check. * Large requests will be assessed differently.

First Year	$ 5.00	$5.00
Additional Year(s)	$ 3.00 X _____	
	FEE TOTAL	

Please allow 60 days for processing your request.
The Disclosure Unit will only provide records once. Records will not be resent without submitting a new 4095 form and fee.
You must submit your request with payment to the following address, "Michigan Department of Treasury, Disclosure Unit does not issue invoices. Please wait 30 days from mailing to check the status of request.

Send this form to:
Michigan Department of Treasury
Privacy and Security, Disclosure Unit
P.O. Box 30832
Lansing, MI 48909
Email: **Treas_Disclosure@michigan.gov**
Allow 60 days to process your request.

Treasury Use Only

1. ☐ The attached information is furnished for tax year(s) _____
2. ☐ No record of filing a return for tax year(s) _____
3. ☐ Other _____
4. ☐ See attached 4374 form for additional information needed

Disclosure Unit Approval Certification	Date Completed

Member Consent for Release of Protected Health Information

Blue Cross Blue Shield Blue Care Network of Michigan

Nonprofit corporations and independent licensees of the Blue Cross and Blue Shield Association

Use this form to allow Blue Cross* to share your protected health information (also known as PHI) with an individual or organization.

A Member who is giving consent

This form can only be used for one member. Please submit a separate form for each member.

Name_____ **Date of birth** _____

Enrollee ID (number on ID card beginning with 1 to 3 letters) _____

Address_____ **Daytime phone** _____

City_____ **State** _____ **ZIP** _____

B Protected health information to be shared *(check one)*

☐ Any and all information (including personal, health, demographic, claims, billing and medical records) except Super PHI. Use the boxes listed below to include Super PHI.

☒ Only limited information (such as for specific treatments, dates of service or billing details)

(please describe) PLEASE SEE ATTACHED SUBPOENA OR LETTER REQUEST

Please check below if you would also like to include any of the following highly protected information (known as Super PHI):

☐ Substance abuse records (including alcoholism)

☐ AIDS or HIV treatment records

☐ Mental health services (does not include psychotherapy notes)

☐ Family Planning

☐ Psychotherapy notes (excluded from mental health)

C Person or organization that may receive your information

Note: If information is shared with a person or organization that is not legally required to obey privacy laws, the information may be shared with others and no longer protected.

Print first and last name for a person, and the most detailed name possible for an organization (for example, hospital name and department).

Recipient's full name RECORDS DEPOSITION SERVICE, P.O. BOX 5054, SOUTHFIELD, MI 48086-5054

Please check the box below describing the person or organization's relationship to you.

☐ Family member

☐ Friend

☐ Doctor or health care provider

☒ Other *(describe)* AGENT FOR ATTORNEY

Form continues on page 2.

* "Blue Cross," "we" or "us" refers to Blue Cross Blue Shield of Michigan, Blue Care Network, Blue Care Network Service Company, Blue Care of Michigan, Inc. or Blue Cross Complete of Michigan.

D Expiration and cancellation

This permission will expire *(check one box only)*:

☐ On this date (month, day and year, MM/DD/YYYY) _____

☐ When canceled, or upon my death

I understand that I can cancel this authorization at any time by submitting a written request on a standard form, available online at **bcbsm.com** or by calling the number listed on the back of my ID card. I understand that cancellation will not apply to information that has been released by this authorization.

E Authorization and signature

I allow the use and disclosure of my protected health information as described above. This information is being released at my request. I understand that my treatment, payment, enrollment or eligibility for benefits does not depend on whether I sign this authorization.

Signature of member

SIGN HERE _____ Date _____

IMPORTANT: Please read the form over carefully and be sure you have included all necessary information. We cannot take additional information by phone, fax or email. If information is missing we will have to contact you and request a new form.

Mail completed consent form to:

Blue Cross Blue Shield of Michigan Mail Code X425
600 East Lafayette Blvd.,
Detroit, MI 48226

or fax to: **1-866-894-3101.**

For additional assistance completing this form, call the number listed on the back of the member's ID card.

AUTHORIZATION TO ACCESS or RELEASE MEDICAL INFORMATION

COGNITIVE PATIENT LABEL

Questions: Contact Medical Records: 313.916.4540
Please mail completed form to: Medical Records 2799 W.Grand Blvd., Detroit, MI 48202 or to Medical Records email address: HFHSMedicalRecords@hfhs.org • fax number 313.916.3917
(Please keep in mind that emails sent over the internet may not be secure.)

Patient Information (please print)

Name (First, Middle, Last)		Maiden name or previous names	
Address	City	State	Zip Code
Date of Birth	Phone	E-mail Address if Applicable	

I authorize my records to be sent from:

Henry Ford Health System:

- ❒ HF Allegiance Health
- ❒ HF Allegiance Specialty Hospital
- ❒ HF Behavioral Health
- ❒ HF Hospital Detroit
- ❒ HF Kingswood Hospital
- ❒ HF Macomb Hospital
- ❒ HF Maplegrove Center
- ❒ HF West Bloomfield Hospital
- ❒ HF Wyandotte Hospital
- ❒ HF Other (Clinic/Medical Center): _____

Other Facility:

Name/Organization			
Address	City	State	Zip Code

I authorize my records to be released to:

Myself:

- ❒ MyChart (patient request)
- ❒ E-mail to me at address above
- ❒ Mailed to me at address above
- ❒ On site inspection. (Authorization is valid only if received by Henry Ford Health System within 60 days of the date signed.)
- ❒ Mailed to address below
- ☑ Faxed to number below
- ❒ Verbal communication about my care. Describe information to be shared: _____

_____

Other: Disclose to - complete information below

Name/Organization RECORDS DEPOSITION SERVICE, INC.			
Address PO BOX 5054	City SOUTHFIELD	State MI	Zip Code 48086-5054
Phone Number 248-357-3330	Fax Number 248-357-3337		

Please complete below if you want to include medical records for these services:

❒ Substance Use Disorder diagnosis and treatment

Purpose: ❒ Continuation of Care ☑ Legal ❒ Personal ❒ Other _____

❒ Psychotherapy Notes

Specific Information Requested:

Type of Record requested		Date of Service	Type of Record Requested		Date of Service
❒	Discharge Summary		❒	Outpatient Record	
❒	Emergency Department		❒	Radiology Report	
❒	Laboratory Report		❒	Office Note	
❒	Immunizations		❒	Other:_____	
❒	Inpatient Record			_____	

By signing this authorization I hereby authorize Henry Ford Health System to disclose information contained in the medical record of the patient identified above, which includes information that may be stored in a paper and/or electronic format, as set forth below. Such notes may contain information on: general medical care, psychological and social work counseling; human immunodeficiency virus (HIV) or acquired immunodeficiency syndrome (AIDS) or AIDS related complex (ARC), as applicable; communicable diseases or infections, including sexually transmitted diseases, venereal diseases, tuberculosis and hepatitis, as applicable; demographic information; and treatment received by other health care providers. Any alcohol and substance use disorder information disclosed to you in these records is protected by Federal confidentiality rules (42 CFR Part 2). 42 CFR Part 2 prohibits unauthorized disclosure of these records. Patient access fee may apply for copies. Fees are authorized annually by the State of Michigan Medical Records Access Act, P.A. 47 of 2004, MCL 333.26269.

I understand that:

- I may revoke (take back) this authorization at any time. Revocations to this authorization must be presented in writing. Revocation will not apply to the information that has already been released prior to receiving the revocation. Contact Henry Ford Health System Medical Records department. Contact information is available at the top of the form.
- This authorization expires when the patient information is disclosed as permitted in this authorization, or within one (1) year from the date that it is signed unless another expiration date is written here: _____ _____ (describe the date/event/condition upon which authorization will expire, which must be no longer than one year from the date signed)
- My care or treatment will not be conditioned on signing this authorization
- The person(s) to whom information is disclosed under this authorization may possibly redisclose the information to others without the patient's knowledge or consent and therefore the privacy of personal and health information may no longer be protected by law.
- Henry Ford Health System and/or its copying service reserve the right to charge for processing and copying information. This fee is waived when releasing information directly to a treating physician or health care facility.

Signature _____ Relationship (if other than patient) _____

Patient, Parent of Minor, Legal Guardian, Personal Representative, Heir at Law, Person under a POA. (if legal guardian, Personal Presentative or person of authority under a durable medical power of attorney, a copy of appropriate documentation may be required)

Date_____ Time_____