RECORDS DEPOSITION SERVICE®
INCORPORATED

MEDICAL AUTHORIZATION

I, hereby authorize

(Patient Name) (Hospital/Doctor Name)

its Director or Designee, or Medical Records Department, to release protected health information contained in my patient records, including information about communicable diseases and serious communicable diseases and infections (which include venereal disease "VD" and tuberculosis "TB"), alcohol, drug abuse, and/or HIV-AIDS test results or diagnostic records protected under the regulations in 42 CFR, Part 2, and Ohio Revised Code §3701.243, if any; psychological or psychotherapy service records, if any; and social services records, if any, including communications made by me to a social worker or psychologist, to the individuals or organization listed below ("Recipient"), only under the conditions listed below. Further disclosures of any/all of these patient records by the Recipient to persons with need to know for all purposes related to claims processing and/or discovery before and during trial/arbitration is hereby expressly authorized.

Birth date of Patient: Social Security Number:

1) Name of Individual(s) or organization(s) to whom disclosure is to be made:

Records Deposition Service *and/or*

Address:

2) Specific type of information to be disclosed:

- ☒ E.R. Report
- ☒ EKG
- ☒ Operative Report
- ☒ Radiology Report
- ☒ Billing Records
- ☒ Discharge Summary
- ☒ MRI
- ☒ Pathology Report
- ☒ EMG Report
- ☒ Entire Chart
- ☒ History & Physical
- ☒ X-Ray
- ☒ Laboratory Report
- ☒ Physical/Occupational Therapy Report

3) The purpose and need for such disclosure: (For mental health records, including a statement as to how the information to be disclosed is germane to the purpose and need for such disclosure.):
For all purposes related to claims processing and/or discovery before and during trial/arbitration.

4) This consent may be revoked by writing to the Hospital/Doctor at any time, except for health information the Hospital/Doctor has already released. Any consent given with respect to alcohol and/or drug abuse records shall have duration no longer than that reasonably necessary to achieve the purpose for which it is given. However, this Authorization will expire one (1) year from the date written below. I understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment.

5) Once certain information is disclosed pursuant to this Authorization, it is subject to re-disclosure by the recipient, and will no longer be protected by the HIPAA Privacy Regulation.

6) **If the records released include information of any diagnosis or treatment of drug or alcohol abuse, the following statement applies to the Recipient:** This information has been disclosed to you from records protected by Federal Confidentiality Rules. The Federal Rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R., Part 2. A general authorization for the release of medical records or other information is not sufficient for this purpose. The Federal Rules restrict any use of information to criminally investigate or prosecute any alcohol or drug abuse client.

7) **If the records released include information of HIV-related diagnosis or test results, the following statement applies to the Recipient:** This information has been disclosed to you from confidential records protected from disclosure by State law. You shall make no further disclosure of this information without the specific, written and informed release of the individual to whom it pertains, or as otherwise permitted by State law. A general authorization for the release of medical or other information is NOT sufficient for the purpose of the release of HIV test results or diagnoses.

8) A Photocopy of this authorization has the effect of an original.

9) I further agree by supplying an authorization that RDS may make changes to the authorization for, e.g., HIPAA compliance needed to obtain the requested records.

10) Statement that covered entity will not condition treatment, payment, enrollment or eligibility for benefits on whether the individual signs the authorization or describe the consequences of refusal to sign an authorization.

____ Date: ______________________

Signature of Patient

____ Date: _______________________ Job #

Signature of Parent/Guardian/Personal Representative

Revised May 30, 2003(1)

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