C D SERVICES, INC.
24027 RESEARCH DRIVE
FARMINGTON HILLS MI, 48335
(248) 476-1700 FAX (248) 476-6600
RECORDS@CDSERVICESINC.COM

MEDICAL AUTHORIZATION

Doctor/Hospital Name: _____

Address: _____

Name of Patient: _____

Address: _____

Date of Birth: _____ SS#: _____ Patient ID:_____

I, the undersigned, hereby authorize the Custodian of the Records of the above referenced entity to release the information which may be requested, by subpoena or request, regarding myself and to allow them or any person appointed by them to examine or photocopy any records regarding me, including records which have been maintained regarding my past or present physical or mental condition and treatment rendered, including but not limited to my consumption of alcohol or use of drugs including those protected under Title 42 of the Code of Federal Regulations, Part 2; Psychological or Psychiatric records, including communications made by me to a social worker, psychologist or psychiatrist; including behavioral or mental health services; any records regarding Human Immunodeficiency Virus (HIV), Acquired Immunodeficiency Syndrome (AIDS), and AIDS Related Complex (ARC); records relating to communicable disease and/or infections, including sexually transmitted diseases, Tuberculosis, and Hepatitis B; and Sickle Cell Anemia, and allow them or any physician appointed by them to examine or copy my records or x rays which you may have regarding my condition or treatment. This authorization meets or exceeds all HIPAA compliance standards. Dates of Treatment to be disclosed: **from** _____ **to present date**. If not otherwise limited, it is my understanding, intent and desire that my entire record be disclosed.

Disclosure is to be made to: **C D SERVICES, INC.** 24027 Research Drive, Farmington Hills, MI 48335 and/or all attorneys of record.

The purpose and need for disclosure is: **For any and all purposes permitted or required by law.**
This consent is subject to revocation, except to the extent that the entity which is to make the disclosure has already acted in reliance on it. If not previously revoked, this consent will terminate upon: _____ (specific date, event or condition.) If not specified, this authorization will expire one (1) year from the date executed. I understand that the information used or disclosed may be subject to re-disclosure by the person or facility receiving it, and would then no longer be protected by federal privacy regulations. CDS shall not be liable for damages as a result of any unauthorized disclosure I may revoke this authorization by notifying any entity named herein, in writing, of my desire to revoke it. I may refuse to sign this authorization and my refusal to sign will not affect treatment, payment, enrollment or eligibility for benefits. A copy of this document has been made available to me.

This authorization is for copying purposes only and does not authorize exparte communication.

A PHOTOCOPY OF THIS DOCUMENT SHALL BE CONSIDERED VALID AS IF THE ORIGINAL WERE OFFERED.

Subscribed and Sworn to before me this

_____ day of _____, 20___.

_____ _____

Notary Public, _____ County, Signature of Patient / Legal Representative

State of _____. (order appointing attached)

My Commission Expires:_____ Date: _____

CDS JOB #: _____