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

INSURANCE RECORDS RELEASE AUTHORIZATION

Deponent 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 and disclose information which may be requested regarding myself and/ or any claims made by me or on my behalf including but not limited to; accident claims, claim reports, witness statements, my past or present medical 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; any records regarding Human Immunodeficiency Virus (HIV), Acquired Immunodeficiency Syndrome (AIDS), Sickle Cell Anemia and AIDS Related Complex (ARC); records relating to communicable disease and/or serious communicable disease and infections, including but not limited to venereal disease, Tuberculosis, and Hepatitis B; and allow them or any physician appointed by them to examine or copy any and all records or x rays which you may have regarding my condition or treatment, photos, diagrams and billings and records you may have to include the complete insurance files, no fault records, complete workers compensation files and any other records of benefits received. Dates to be disclosed: from (date) _____ to (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 #: _____