Legal-Ease
Digital Imaging
A Limited Liability Company

P.O. Box 1017
Flint, Michigan 48501-1017
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Authorization for Release of Medical Records

PATIENT INFORMATION

Name on Record:_____ DOB_____ SSN_____

INFORMATION TO BE RELEASED FROM

Name of Facility or Provider_____
Address_____

INFORMATION TO BE RELEASED: (Check One)

____All Medical Records
____The most recent 2 years of pertinent information (Chart notes, labs, x-rays and special tests)
_x_Specific information: _____
_____

INFORMATION TO BE RELEASED TO

Name of Designed Recipient Legal-Ease Digital Imaging, LLC
Address PO Box 1017 City Flint State MI Zip 48501-1017

PURPOSE FOR WHICH DISCLOSURE IS BEING MADE: (Check One)

_x_ Attorney _____ Insurance _____ Doctor _____ Personal

PATIENT AUTHORIZATION

I understand that my records may contain information regarding the diagnosis or treatment of HIV/AIDS, sexually transmitted diseases, veneral disease "VD", tuberculosis "TB", hepatitis B, infectious disease, drug and/or alcohol abuse, mental illness, or psychiatric treatment. I give my specific authorization for these records to be released.

EXCLUDE the following information from the records release (Please Initial)

____ Drug/Alcohol Abuse/Treatment & Diagnosis _____ Sexually Transmitted Disease
____ HIV/AIDS Diagnosis/Treatment/Testing ____ Mental Illness or Psychiatric Diagnosis/Treatment

MY RIGHTS

I understand this authorization is voluntary and that my continued or future treatment by or payment to the Releasing Party, enrollment, or eligibility of benefits is not conditioned on my providing or signing this authorization. I may revoke this authorization in writing. To review the process for revoking this authorization, please read the Privacy Notice to patients posted at the facility where your information is being released. I also understand that any use or disclosure made prior to the revocation under this authorization will not be affected by revocation. I understand that once the health information I have authorized to be disclosed reaches the noted recipient, that person or organization may redisclose it, at which time it may no longer be protected under Privacy laws. This authorization also permits, but does not require, oral communications regarding my medical condition between agents of the Receiving Party and the Releasing Party identified above.

Signature _____ Date _____
Patient, Guardian or Authorized Representative

Subscribed and sworn to before me this
_____ day of _____, 20___

_____
Notary Public _____County
My Commission Expires: _____ **This authorization will expire one year from the date signed**