Legal-Ease
Digital Imaging
A Limited Liability Company

2496 Meadowcroft Dr Burton, MI
48519
855.534.4003 / 810.234.7799 p
810.547.4030 f

Authorization for Release of Academic Information

School Name & Address:_____

Name of Student:_____ Date of Birth_____ S.S. #:_____

I, the undersigned, hereby authorize the director or designee or the academic records department of the above named facility, to disclose all information and records stored in a paper and/or electronic format of the person identified above, identified by the attached letter or subpoena. I authorize this information is to be released to:

Legal-Ease Digital Imaging LLC
2496 Meadowcroft Dr.
Burton, MI 48519

1. **I understand this authorization expires 60 Day's after it is signed. I understand I have the right to revoke this authorization at any time. I understand that the revocation must be done in writing and be sent to the above-named provider of records.**
2. **I understand that protected information in my records may include drug and alcohol abuse records, psychiatric and/or psychological records, social work records, venereal disease "VD", tuberculosis "TB", hepatitis B, infectious disease communicable diseases and infections, and any information related to HIV/AIDS and AIDS related complex-ARC.**
3. **I understand this authorization is for the specific purpose of providing my records to an attorney for purposes of a claim or pending litigation.**
4. **I understand, and fully endorse, that a photocopy, scanned image, fax or an e-mail of this authorization shall have the same force and effect as the original.**

_____ _____

Signature of Student/Personal Representative **Date**

_____

Print Name of Student/Personal Representative

If signed by anyone other than the Name on Record, please indicate your authority to sign:

__Personal Representative __Parent of Minor __ Conservator __Legal Guardian __Power of Attorney

Subscribed and Sworn before me
this _____ day of _____, 20____

_____
Notary Public: _____County
My Commission Expires:_____