



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

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)
☒ Specific information: _____

INFORMATION TO BE RELEASED TO

Name of Designed Recipient Legal-Ease Digital Imaging
Address 2496 Meadowcroft Dr City Burton State MI Zip 48519

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

☒ 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, venereal 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.

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 60 Days from the date signed