



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 Protected Information

Name on Record: _____

Date of Birth _____ Social Security Number: _____

I hereby authorize _____

To release the following protected records _____

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.
2. 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.
3. I have signed this authorization voluntarily. I understand that my refusal to sign this authorization will not affect my relationship with the above-named provider. I understand that my continued or future treatment by or payment to the Releasing Party, enrollment, or eligibility for benefits is not conditioned upon my providing or signing this authorization.
4. I understand that protected information in my records may include drug and alcohol abuse records, psychiatric and/or psychological records, social work records, communicable diseases and infections, and any information related to HIV/AIDS and AIDS related complex-ARC.
5. I understand this authorization is for the specific purpose of providing my records to an attorney for purposes of a claim or pending litigation.
6. 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 Patient/Personal Representative

Date

Print Name of Patient/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