McKENZIE HEALTH SYSTEM
Experience Our Difference

AUTHORIZATION FORM: RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name (print) _____ Date of Birth _____

By signing this Authorization Form, I understand that I am giving my authorization to McKenzie Health System's designated health information technicians or designee to use and/or disclose my protected health information (PHI), as described in more detail, to the following person(s) or organization(s):

1. Name of person(s) or organization(s): Legal-Ease Digital Imaging LLC

   Address: 2496 Meadowcroft Dr City Burton State MI Zip 48519

   Telephone Number: 855-543-4003 Fax Number: 810-547-4030

   Specific description of information requested (*ie: name of test, date of service or timeframe*): _____

   _____

2. I understand the information to be used or disclosed pursuant to this authorization form may include information relating to: (1) Acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV) infection; (2) treatment for drug or alcohol abuse; or (3) mental or behavioral health or psychiatric care, including psychotherapy notes.

3. Authorization for release of health information is provided to the receiving party for the purpose of:
   - ☐ Treatment by another health care provider
   - ☐ Deceased records (please refer to form F-5330)
   - ☒ Other: Litigation
   - ☐ Personal copy for own records
   - ☐ Providing data for fundraising activities
   - ☐ Providing data to be used for marketing purposes
   - ☐ **Diagnostic Images: Email Address for link invite**: pat.legalease@gmail.com

4. I understand that the information disclosed pursuant to this authorization may be re-disclosed by the recipient and no longer protected by federal or Michigan privacy law.

5. I understand that this authorization is voluntary and I can refuse to sign the authorization. Continued or future treatment by the disclosing facility is not conditioned upon my providing this authorization unless this authorization is for providing data in connection with medical or clinical trial research. I understand that I may inspect or copy the information to be used or disclosed as provided in CFR 164.524.

6. I have the right to revoke this authorization at any time, by presenting written revocation to the Health Information Management Department (please refer to form F-5329). I understand that revocation will not apply to information that has already been released in response to this authorization or to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

7. If I am providing authorization for marketing purposes, I understand that McKenzie Health System may receive renumeration from a properly authorized business associate as a result of using or disclosing the patient's protected health information.

8. I understand that the following risks apply when sending information by the email/internet method: Email can be circulated, forwarded, stored electronically/on paper and broadcast to unintended recipients. Email senders can easily misaddress an email. Backup copies of email may exist even after the sender or the recipient has deleted his or her copy. Employers and on-line services have a right to inspect email transmitted through their systems. Email can be intercepted, altered, forwarded, or used without authorization or detection. Email can be used to introduce viruses into computer systems. Email can be used as evidence in court. Emails may not be secure, including at McKenzie Health System and therefore it is possible that the confidentiality of such communications may be breached by a third party. I acknowledge that I have read and fully understand the risks associated with sending my PHI via email.

   ☒ By checking this box, I agree to have my PHI sent via email to the email address listed below:
   Email address: pat.legalease@gmail.com

_____ _____
Signature of Patient or Personal Representative (If signed by Legal Representative, attach a copy of document) Date

Printed Name of Patient or Personal Representative, if applicable: _____

Relationship to Patient Giving Representative Authority to Act for Patient, if applicable: _____

Witness Signature: _____ Date: _____

Expiration date: This authorization will expire in one year, unless otherwise specified: _____