



AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION
(INSPECTION AND/OR COPY)

PATIENT NAME: _____

Medical Record #: _____ Acct #: _____

Date of Birth: _____ Date of Service: _____

1. The following individual(s) or organization(s) are authorized to make the use or disclosure: _____
2. The information to be used or disclosed is as follows: (include specific meaningful description)

3. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) and AIDS Related Complex (ARC), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, treatment for alcohol and drug abuse, or serious communicable diseases as defined by the Department of Public Health Rules including Hepatitis B, Venereal Disease and Tuberculosis.
4. The information identified above may be used by or disclosed to the following individual(s) or organization(s):
Name: Legal-Ease Digital Imaging LLC
Address: 2496 Meadowcroft Dr Burton, MI 48519 PH: 855-543-4003 FX: 810-547-4030 pat.legalease@gmail.com
5. This information for which I am authorizing disclosure will be used for the following purposes:
Litigation
6. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Director of Health Information Management. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.
7. This authorization will expire _____. If I fail to specify an expiration date or event, this authorization will expire one year from the date of which it was signed.
8. I understand that once the above information is disclosed, it may be redisclosed by the recipient and the information may not be protected by federal privacy laws or regulations, although, such use/disclosure may be subject to other Michigan and federal laws.
9. I need not sign this form as a condition of receiving healthcare treatment.
10. This authorization follows Memorial Healthcare's Authorization Policy and Procedure.

Signature of patient or legal representative

Date

Signature/Relationship of other Authorized Person

Date

Signature of witness

Date

I hereby acknowledge receipt of this authorization. _____

Memorial Healthcare/ 826 W. King St. / Owosso, MI 48867

Distribution of copies: Original to Memorial Healthcare and copy to patient and/ or authorized person.