

Patient Name: _____ Medical Record # _____ Date of Birth _____

Address: _____

Telephone _____

For the period(s) of health care from (date) _____ to (date) _____

1. Requesting Information from (**specify Shriners Hospitals for Children Facility**): _____ to disclose to:

Name: Legal-Ease Digital Imaging LLC

pat.legalease@gmail.com

Street Address: 2496 Meadowcroft Dr

Phone # 1-855-543-4003

City, State & Zip Code: Burton, MI 48519

Fax # 810-547-4030

2. Information to be disclosed:

- | | | |
|---|---|---|
| ☐ Discharge summary | ☐ Progress notes | ☐ Operative reports |
| ☐ History & physical examination | ☐ Laboratory tests | ☐ Consultation reports |
| ☐ X-ray reports | ☐ X-ray films/images | ☐ Photographs/slides |
| ☐ Billing Statements | ☐ Other _____ | |

3. Reason for disclosure: _____

4. Separate signature required for release of information related to items below. Initial each line if required.

- ____ Acquired immunodeficiency syndrome (AIDS) or infection with human immunodeficiency virus (HIV)
- ____ Behavioral health services/psychiatric care/psychotherapy records
- ____ Alcohol and substance abuse diagnosis and treatment records
- ____ Pregnancy, contraceptives, and sexually transmitted diseases
- ____ Genetics testing

Signature for release of information in Item 4: _____

5. I understand this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization. **Unless otherwise revoked, this authorization will expire one year (12 months) from the original date for release of information to family members; six (6) months from the original date for all other releases.**

6. I have had the opportunity to ask questions regarding this Authorization and these questions have been answered fully.

7. I hereby release and agree to indemnify and hold harmless Shriners Hospitals for Children, its successors and assigns, and its agents and employees, from and against any claim or cause of action based on the release of requested health records and/or health information I previously authorized.

8. The recipient of this information might disclose it to other people. Shriners Hospitals for Children has no way to prevent this re-disclosure and cannot be held liable for such re-disclosures.

☐ I understand that I do not have to and have chosen not to sign this Authorization. My failure or refusal to sign will not affect my child's or my treatment or ability to receive treatment at Shriners Hospitals for Children.

Signature of patient (14 years or older) Date Time AM/PM

Signature of the Parent/Legal Guardian Date Time AM/PM

Print Name Relationship to Patient

Signature of the Witness Date Time AM/PM

Name (Print)

Signature of the Parent/Legal Guardian Date Time AM/PM

Print Name Relationship to Patient

Signature of the Witness Date Time AM/PM

Name (Print)

Authorization for Disclosure of Health Information
Shriners Hospitals for Children®



Patient Information Label