

Authorization for Release of Health Information

Member's name/Person granting access _____

Date of birth ____ / ____ / ____ Member or subscriber ID# _____
MM DD YYYY

Member's street address _____ City _____ State ____ ZIP _____

I understand and agree that:

- This authorization is voluntary.
- My health information may contain information created by other persons or entities including health care providers and may contain medical, pharmacy, dental, vision, mental health, substance abuse, HIV/AIDS, psychotherapy, reproductive, communicable disease and health care program information.
- I may not be denied treatment, payment for health care services, or enrollment or eligibility for health care benefits if I do not sign this form.
- My health information may be subject to re-disclosure by the recipient, and if the recipient is not a health plan or health care provider, the information may no longer be protected by the federal privacy regulations.
- This authorization will expire one year from the date I sign the authorization. I may revoke this authorization at any time by notifying UMR and its affiliates in writing; however, the revocation will not have an effect on any actions taken prior to the date my revocation is received and processed.

Who may receive and disclose my information:

I authorize UMR and its affiliates to receive from or disclose my individually identifiable health information to the following person(s) or organization(s):

Full name of person(s) or organization(s) Pat Clifford - Legal Ease Digital Imaging LLC

Full address of person(s) or organization(s) 2496 Meadowcroft Dr Burton, MI 48519

Description of individually identifiable health information to be received or disclosed

(check appropriate type(s) of information):

- | | |
|---|---|
| ☒ All | ☐ Treatment plan(s) |
| ☐ Claims | ☐ Progress reports |
| ☐ Eligibility/benefits | ☐ Attendance only |
| ☐ Information used to make benefit determinations | |
| ☐ All pertinent information UMR deems appropriate for the purpose checked below | |
| ☐ Other (describe): _____ | |

The purpose of this authorization is (check all that apply):

- | | |
|--|---|
| ☐ To allow the appropriate management of treatment, services, and/or coverage under the member's benefit plan. | |
| ☐ Benefit management | ☐ Administration of a worker's compensation claim |
| ☐ Claims administration/payment | ☐ Administration of a disability claim |
| ☐ Employer mandated treatment referral | ☐ Subpoena or other legal process |
| ☒ Other (describe): Litigation | ☐ CARE programs |

The dates of records to be disclosed:

From / / To / /
MM DD YYYY MM DD YYYY

The member or member's representative must complete the rest of this form:

I understand that this authorization will expire:

☐ On / /
MM DD YYYY

Signature of member (Required) _____ Date / /
MM DD YYYY

Witness signature (For Illinois residents only) _____ Date / /
MM DD YYYY

Please note: If you are a guardian or court appointed representative, you must attach a copy of your legal authorization to represent the member.

Signature of member's representative _____ Date / /
MM DD YYYY

Print name _____ Phone number - -

Street address _____ City _____ State _____ ZIP _____

Signature of minor member _____ Relationship to member _____

Description of representative's authority _____

Please return the completed form to:

UMR, P.O. Box 30541, Salt Lake City UT 84130-0541 or Fax: 888-742-4179

For California and Georgia residents only

I understand that I may see and copy the information described on this form if I ask for it, and that I may receive a copy of this form after I sign it.

Please maintain a copy of this document for your records.