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AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION

Resident _____

Facility _____

I authorize the Facility to disclose my health information, as described below:

☑ Entire Medical Record

----------OR---------

Partial Medical Record, including the following information:

☐	Physician Orders	☐	Interdisciplinary Progress Notes
☐	Laboratory Results	☐	Diagnostic Reports
☐	Medication Administration Records	☐	Treatment Administration Records
☐	Consultation Reports	☐	Other (please describe below)

_____

_____

I request that my medical records be produced in the following manner:

☑ Electronic copies produced via **CD or USB Jump drive** (**circle one only**) and sent to me via Fed Ex at: LegalEase Digital Imaging LLC 2496 Meadowcroft Dr Burton, MI 48519

_____

☑ Electronic copies produced via secure electronic link to following email pat.legalease@gmail.com

I understand that I will be charged the reasonable cost based fee for completing this request and, if mailed, for the Fed Ex shipping charges. I understand that I must provide payment in response to the invoice for the release of the requested records.

I understand that the disclosure of my medical record could include information relating to acquired immunodeficiency Syndrome(AIDS), human immunodeficiency virus (HIV), behavioral health services of psychiatric care, mental health treatment, or treatment for alcohol and/or drug abuse, and by my signature, I understand that I am waiving and privilege applicable to these records and expressly authorizing the disclosure of this information.

I consent for the Facility to release my medical records to the following individual, entity or organization:

LegalEase Digital Imaging

I expressly waive any laws, regulations and rules of ethics which might prevent any health care provider who has examined or treated me from disclosing my records pursuant to this Authorization.

I understand that if the person or entity receiving the information is not a healthcare provider or health plan covered by the federal Privacy Rule, the information disclosed as described above may be re-disclosed and no longer protected by the Rule. I understand that I may revoke this authorization in writing at any time through a written letter addressed to the organization's Medical Record coordinator, except to the extent that action has been taken in reliance on the authorization.

AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION (CONTINUED)

This authorization shall expire one year from the date of the execution of this release.

I understand that I, or anyone authorized to act on my behalf, will be required to pay any sums due for the cost of the production of the requested records.

I understand that I am not required to sign this authorization as a condition of my ability to obtain treatment or for payment of my eligibility for benefits.

I understand that I may inspect or copy any information disclosed under this authorization, as well as refuse to sign this authorization.

By signing below, I acknowledge that I have read and understand this authorization form.

SIGNATURE OF RESIDENT DATE

If signed by the resident's Authorized Representative, please provide the following information:

Printed Name Signature

Relationship to Resident Date

Any documentation that establishes the legal authority of the authorized representative (e.g. Power of Attorney, Health Care Surrogate Appointment documentation, Guardianship documentation, or court order) to obtain the Resident's protected health information must be provided with this executed authorization.

If the resident is deceased, please provide the following information:

AUTHORIZED RELATIVE CERTIFICATION

I, _____ (insert name of authorized relative), certify that I am an authorized relative of the deceased _____ (insert name of deceased). (**A CERTIFIED COPY OF THE DEATH CERTIFICATE MUST BE ATTACHED**.) I certify that to the best of my knowledge and belief that no executor or administrator has been appointed for the deceased's estate, that no agent was authorized to act for the deceased under a power of attorney for health care, and the deceased has not specifically objected to disclosure in writing.

_____ I certify that I am the surviving spouse of the deceased
OR
_____ I certify that there is no surviving spouse and my relationship to the deceased is (**circle one**):
(1) An adult son or daughter of the deceased.
(2) Either parent of the deceased.
(3) An adult brother or sister of the deceased.

This certification is made under penalty of perjury. *

_____ _____

Print Authorized Relative's Name Signature of Authorized Relative