

**AUTHORIZATION FOR THE RELEASE OF  
WRITTEN ACADEMIC AND/OR EMPLOYMENT RECORDS**

**TO:** \_\_\_\_\_  
\_\_\_\_\_

You are hereby authorized and requested to furnish the record copy service designated below copies of:

- 1) **all academic records** including, but not limited to all applications, test scores, progress reports, counseling records, scholarship and grant records, disciplinary records, correspondence, medical records, electronic correspondence, e-mails or other electronic internal communications, etc., and any further information which may be available to you; and/or
  
- 2) **all employment records** including, but not limited to all employment applications, volunteer records, membership records, physical exam reports, medical records/reports, accident reports, workers' compensation records, insurance records, earnings records, W-2's, attendance records, job descriptions, job performance reviews, disciplinary records, electronic correspondence, e-mails or other electronic internal communications, etc., and any further information which may be available to you.

**I understand** that any medical records produced may include information relating to communicable diseases and infections, sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), AIDS related complex (ARC), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, including communications made by any psychologist, psychiatrist or social worker. I understand that my medical record may also include treatment of and/or testing for alcohol and drug use and/or abuse.

**Person/entity authorized to receive the above described records** – PROACTIVE RECORD COPY SOLUTIONS, POST OFFICE BOX 210, GRAND HAVEN, MI 49417 / PHONE: 616.681.9088 / FAX: 866.548.7941.

**Purpose of the release** – The records are to be released for the purpose of discovery of information in connection with civil litigation or anticipated civil litigation.

**Duration of the authorization** – This authorization will expire six (6) months from the date it was signed.

**Revocation** – I may revoke this authorization at any time by written direction to any records custodian, except as to any information already released in reliance on this authorization form.

**Further disclosure** – I understand that the information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and the information may not be protected by federal privacy laws or regulations.

**Ex-parte communications** – I do not authorize ex-parte communication with any person or entity, except my attorneys, without further written authorization.

**I understand** that this authorization is voluntary and that any employment or education I may seek will not be conditioned upon my signing this authorization.

**A photocopy** of this authorization may be used in the place of the original.

**NAME ON RECORD:** \_\_\_\_\_

**DATE OF BIRTH:** \_\_\_\_\_

Date Signed: \_\_\_\_\_  
SIGNATURE OF \_\_\_\_\_

Date Signed: \_\_\_\_\_  
WITNESS \_\_\_\_\_