

**AUTHORIZATION FOR THE RELEASE OF WRITTEN RECORDS**

- TO:**
- 1) State of Michigan Family Independence Agency  
Attn: Bureau of Legal Affairs, 235 S. Grand Street, Ste. 1518, Lansing, Michigan 48933
  
  - 2) State of Michigan Bureau of Workers' Disability Compensation  
7150 Harris Drive, Post Office Box 30016, Lansing, Michigan 48909
  
  - 3) Social Security Administration
  
  - 4) Centers for Medicare & Medicaid Services  
233 North Michigan Avenue, Suite 600, Chicago, IL 60601-5519
  
  - 4) The following Insurance Company(s) \_\_\_\_\_

You are hereby authorized and requested to furnish the record copy service designated below copies of ALL records in your possession regarding the individual named below, including, but not limited to all medical records, application(s) for benefits/coverage and benefit/coverage records, written and electronic correspondence, e-mails or other electronic communications, determinations, re-determinations, appeal records, monthly benefit records, no-fault files, collision files, property damage files, declaration sheets, workers' compensation files, case management records, Medicare and Medicaid records, etc.

**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 benefits or coverage 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