

AUTHORIZATION FOR RELEASE OF WRITTEN MEDICAL RECORDS

TO: _____

You are hereby authorized and requested to furnish the record copy service designated below copies of ALL records in your possession regarding the physical or mental condition, injuries or diseases of the individual named below for which you have been consulted, or for which you have provided services, including, but not limited to prescription records, x-ray and imaging records and reports, inpatient and outpatient hospital records, admission and discharge records, history & physical records, operative reports, emergency room reports, consultations, laboratory reports, office notes/records, billing records (inclusive of HCFA 1500 and UB92 forms), written and electronic correspondence, e-mails or other electronic communications, 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.

Description of the information to be disclosed – I authorize the release of

- MY ENTIRE MEDICAL RECORD from initial date of service through the present
 MEDICAL RECORDS LIMITED TO THE FOLLOWING TYPES OR DATES:

I recognize that under the **Federal Final Privacy Rule**, I may limit the scope of the information that I authorize be disclosed. It is my express wish that *MY ENTIRE MEDICAL RECORD*, as described above, be released, subject only to the limitations, if any, noted above.

Person/entity authorized to receive my protected health information – PROACTIVE RECORD COPY SOLUTIONS, POST OFFICE BOX 210, GRAND HAVEN, MI 49417 / PHONE: 616.681.9088 / FAX: 866.548.7941.

Purpose of the release – In connection with civil litigation or anticipated civil litigation, the records are to be released for the purpose of discovery of information about my medical or mental condition.

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

Revocation – I understand that I may revoke this authorization at any time by written direction to any provider, 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 no longer be protected by this rule.

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 signing this authorization is voluntary and that any treatment 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