

Axiom Requisition Copy Service
 447 North Canal Road, Lansing, Michigan 48917
 517.886.5099 – 877.886.5090 toll free – 517.886.4116 facsimile

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

TO:

REGARDING:

| | | |
|---------------------------------|-------------------------------|----------------------|
| | | |
| PATIENT'S NAME / ADDRESS | SOCIAL SECURITY NUMBER | DATE OF BIRTH |

2. I, the undersigned, hereby authorize the records custodian or the medical records department or the director or designee of the above named (the "Releasing Party") to release or disclose health information to Axiom Requisition Copy Service, an agent of the "Receiving Party".
3. This authorization is made in accordance with the federal and state law and is valid for a period of 12 months after being signed or at the conclusion of the following legal action, whichever is later:
4. I understand that I may revoke this authorization at any time by sending a written revocation to above mentioned custodian, except to the extent that it has taken action in reliance on the authorization.
5. I understand that once my health information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure or release by the Receiving Party and may no longer be protected by federal or state law.
6. A description of the health information I authorize for use or disclosure is: All personnel/employment contract labor/self-employment records; Workers' Compensation records; Social Security Records; income tax returns, 1040's, 1099's; educational records and files, pharmacy records; dental records; any and all records and documents in their possession pertaining to any treatment/consultation rendered or performed - including but not limited to complete in-patient and outpatient hospital records, emergency room records, rehabilitation records, therapy, lab studies, all radiographic films and reports and actual office notes, patient files, narrative reports and medications prescribed and filled; fresh slides made of any and all specimens, including those obtained of the heart where applicable, complete autopsy report, as well as all other records kept in or for the pathology / forensics department, photographs copied as originals where applicable. This authorization is to include alcohol, mental health and substance abuse records – this request for records includes records protected under the regulations of 42 Code of Federal Regulations, Part 2, if any. This request also includes HIV and AIDS records – and all records defined by the statute and MDPH Rules (Public Act 174, 1989), if any. This authorization also permits (but does not require) oral communications regarding my medical condition between agents of Receiving Party and the Releasing Party identified above. Notice is hereby given to the authorizing party and his/her counsel that agents of the Receiving Party will be requesting oral communication with the Releasing Party regarding my medical condition. This authorization includes health information, both prior to and following the date of this authorization not to exceed its expiration as defined in Line 3 above.
7. This authorization for release of my health information is provided in connection with the legal action referred to above in which allegations of wrongful conduct, damage or loss have been made making the above information discoverable under state law and authorizes the Receiving Party to use and disclose this health information for any and all purposes associated with this legal action which includes: review by experts, disclosure to other counsel or parties, disclosure as part of official pleadings or court documents, review by an independent medical examiner, as part of a mock jury or other trial analysis process which may involve review by outside third parties.
8. I understand that my continued or future treatment by or payment to the Releasing Party is not conditioned upon my providing or signing this authorization.
9. A photocopy of this consent is as valid as the original.
10. I have been provided with a copy of this authorization for my records. _____ (initials)

PATIENT SIGNATURE _____
DATE

PARENT / LEGAL GUARDIAN SIGNATURE _____
RELATIONSHIP _____
DATE

PERSONAL REPRESENTATIVE (DECEASED PATIENT) _____
DATE

PLEASE INCLUDE LETTER OF AUTHORITY TO ACT FOR THIS INDIVIDUAL

SUBSCRIBED AND SWORN BEFORE ME
 THIS _____ DAY OF _____, 20 _____

 NOTARY PUBLIC _____ COUNTY

MY COMMISSION EXPIRES: _____