Legal Eagle
COPY SERVICE, L.L.C.
8585 PGA Drive, Suite 103 • Walled Lake, Michigan 48390
Phone (248)960-9291 • Fax (248)960-9289

AUTHORIZATION TO RELEASE MEDICAL INFORMATION
HIPAA Compliant

Facility Name:
Facility Address:

Patient Name:
Date of Birth:
S.S. #:

I, the undersigned hereby authorize the above named facility, its directors or agents, to disclose information and records of the person identified above, which includes information that may be stored in a paper and/or electronic format. I authorize my information to be released to:

Legal Eagle Copy Service, LLC
8585 PGA Drive, Suite 103
Walled Lake, MI 48390

For the purpose of legal discovery, reproduction and distribution in the course of litigation. This authorization shall permit the listed recipient to examine, photocopy and/or receive any records or information pertaining to the above named individual.

Specific records to be disclosed are those records in your possession pertaining to the above mentioned person birth to present, this includes, but is not limited to any condition(s), treatment(s), opinion(s), illness(es), injury(ies), medical history, consultation(s), prescription(s) and billing(s) regarding the above named, including alcohol and drug abuse records protected under the regulations in 42 Code of Federal Regulations, part 2, psychological/psychiatric and social work records, and any information regarding communicable diseases and infections as defined by the Michigan Department of Public Health rules which can include venereal disease, tuberculosis, HIV, AIDS or ARC, and psychological service and social service records including communications made to a social worker, psychologist, or psychiatrist, if any.

I understand that the information used or disclosed pursuant to this authorization may be disclosed and reproduced by the recipient through the course of the pending litigation and may no longer be protected by the Federal Privacy Rules or other such applicable laws.

The forgoing authorization shall continue in force for 120 days from date of signature, or until revoked by me in writing. I understand that I may revoke this consent at any time, in writing to the facility and recipient identified above, except to the extent that action has already been taken to comply with it.

This authorization is voluntary. I understand that the facility will not base treatment, payment, enrollment, or eligibility for benefits on my signing this document.

A copy of this authorization shall be as valid as the original.

Date: _____

Signature: _____

Personal Representative/Parent/Legal Guardian: _____

Subscribed and sworn to before me this _____ day of _____, 20_____

Notary Public:_____