Axiom Requisition Copy Service
2869 Jolly Road, Okemos, Michigan 48864
517.886.5099 – 877.886.5090 toll free – 517.886.4116 facsimile

HIPAA COMPLIANT AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

I authorize the following specific entity to make the requested use or disclosure of protected health information as described below:

REGARDING:

1.			
	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 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:
4. I understand that I may revoke this authorization at any time by sending a written revocation to the above-named entity, 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:

   This authorization may 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 may also include HIV and AIDS records – and all records defined by the statute and MDPH Rules (Public Act 174, 1989), if any.
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, the undersigned, understand that the recipient of the information provided may make further disclosure of this information that may not be subject to the protections set forth in 45 CFR Parts 160 through 164, including, but not limited to 164.512(e). 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)

THIS FORM MUST BE FULLY COMPLETED BEFORE SIGNING.

PATIENT SIGNATURE **DATE**

PARENT / LEGAL GUARDIAN SIGNATURE **RELATIONSHIP** **DATE**

PERSONAL REPRESENTATIVE (DECEASED PATIENT) **DATE**

PLEASE INCLUDE LETTER OF AUTHORITY TO ACT FOR THIS INDIVIDUAL

A copy of this completed, signed, and dated form must be given to the individual or person signing on the individual's behalf.

SUBSCRIBED AND SWORN BEFORE ME

THIS ___________DAY OF __________________________, 20 _______

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NOTARY PUBLIC ____________________________________COUNTY

MY COMMISSION EXPIRES: ___________________________________

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