AUTHORIZATION FOR THE RELEASE OF MEDICAL/EMPLOYMENT INFORMATION

FACILITY NAME _____

FACILITY ADDRESS _____

CITY _____ **STATE** _____ **ZIP** _____

SSN _____ - _____ - _____ **DOB** _____ / _____ / _____

MAIDEN NAME/ALIAS _____

I, _____ , authorize you and any doctor, nurse, hospital, current or past employer to release:

DATES OF SERVICE _____

To: U.S. Legal Support, Inc., 200 W. Jackson Blvd., Suite 600, Chicago, IL 60606

THE INFORMATION BEING SOUGHT IS TO BE USED IN THE EVALUATION OF A PENDING LEGAL SUIT.

Failure to authorize release of this information may cause a delay in the processing of the suit. A photo static copy of this authorization shall serve in its stead.

This information may include alcohol and drug abuse records protected under the regulations in code 42 of federal regulations, part 2, if any, psychological services records, if any, and social work records, if any, including communications made by me to a social worker or psychologist.

CONSISTENT WITH MICHIGAN PUBLIC ACT 488 OF 1988, THIS AUTHORIZATION ALSO INCLUDES DISCLOSURE OF ANY INFORMATION IN MY RECORDS PERTAINING TO ANY COMMUNICABLE DISEASES OR INFECTIONS, IF ANY, INCLUDING HIV INFECTION, ACQUIRED IMMUNODEFICIENCY SYNDROME, AIDS RELATED COMPLEX, VENEREAL DISEASE, TUBERCULOSIS, MENINGITIS, GIARDIASIS, HEPATITIS A, B, AND NON A, NON B, HISTOPLASMOSIS, LEGIONNAIRES' DISEASE, SALMONELLOSIS, SHIGELLOSIS AND STAPHYLOCOCCAL INFECTIONS.

Information obtained with this release may be subject to the re-disclosure by the recipient and will no longer be protected by rule 164.508(c) of the HIPAA regulations.

THIS AUTHORIZATION IS VALID FOR _____ AFTER IT IS SIGNED, BUT MAY BE REVOKED UPON WRITTEN REQUEST TO:

U.S. LEGAL SUPPORT, 200 W. JACKSON BLVD., SUITE 600, CHICAGO, IL. 60606 AND/OR FACILITY LISTED ABOVE. RECORDS MAY HAVE ALREADY BEEN RELEASED BASED UPON A PREVIOUS AUTHORIZATION. PATIENT OR AUTHORIZED REPRESENTATIVE SIGNING THIS AUTHORIZATION UNDERSTANDS IS VOLUNTARY AND THEY MAY REFUSE TO SIGN. TREATMENT OR PAYMENT WILL NOT BE CONDITIONED UPON THIS AUTHORIZATION OR REVOCATION OF THIS AUTHORIZATION UNLESS OTHERWISE ALLOWED BY LAW.

SIGNATURE _____ **DATE** _____

(PATIENT/PARENT/GUARDIAN/CONSERVATOR/SPOUSE/EMPLOYEE)