HIPAA PRIVACY AUTHORIZATION
FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Relevant to Litigation, Pending Claims or Intent to Sue

Patient's Name:____

Address: ____ Date of Birth:______

1. This Authorization is directed to and applies to protected health information maintained by: (Hospital, Physician, Medical Provider, etc.) ____

____

2. I hereby authorize the above, its director, administrative and clinical staff or assignees, medical information services and billing departments to release any and all medical records and information relating to my care and treatment including x-rays, photographs, electronic and digital files and any other records, unless I expressly direct or specify otherwise. I understand that medical information may include records, if any, relating to treatment for alcohol and drug abuse protected under the regulations in 42 C.F.R. Part 2; psychiatric/psychological services and social work records and any information regarding communicable diseases and infections, defined by Michigan Department of Public Health Rule, which can include tuberculosis, venereal diseases, sexually transmitted diseases, acquire immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV) or ARC.

3. This information is to be released for copying purposes to: **Miller & Miller, P.C.**
6803 Roosevelt Avenue
Allen Park, MI 48101
(313) 386-1400

4. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by the Federal Privacy Rules.

5. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and send it to the hospital, doctor, or other custodian of medical information. I understand that the revocation will not apply to information that has already been released in response to this authorization.

6. A copy of this authorization is as valid as the original.

All Pertinent Sections Of This Form Must Be Completed Before Signing

Dated: ______________________________

____
Signature of Patient or of Personal Representative

____
Description of Personal Representative's Authority

____
Print Name of Patient or of Personal Representative

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________________________________, Notary Public
_______________ County, Michigan
My Commission Expires: ________________________