LEGAL COPY SERVICES
INCORPORATED
™

721-B KENMOOR AVE SE PO BOX 2845 GRAND RAPIDS, MI 49501 PHONE: (616) 949-1614 FAX: (616) 949-6472

AUTHORIZATION FOR RELEASE OF EMPLOYMENT INFORMATION

1. _____ _____ _____
Employee Name Social Security Number Date of Birth

2. I, the undersigned, authorize the following specific entity to release any and all information requested by the accompanying subpoena or letter, or as noted in paragraph 4 below, to **Legal Copy Services, Inc.,** an agent of the receiving party (ies):

_____
(Employer)
_____

_____

3. I understand that unless I expressly direct otherwise, I am authorizing the above person/agent and/or company to deliver to the requesting party the original information or a true exact copy of the original information accompanied by a signed copy of the provided verification statement, or to make such information available for copying, and that the information requested includes all information contained in my file, including but not limited to: employment application information, earnings information; time and attendance records; worker's compensation claims, as well as any and all medical records or medical reports that may contain information about HIV, AIDS, and/or ARC.

4. A description of the information I authorize for use and disclosure is:

5. This authorization is valid for twelve months after being signed, or until the conclusion of the following:

6. I understand that the entity identified in paragraph 2 above will not condition treatment, payment, enrollment or eligibility for benefits on whether or not I sign this authorization

7. This authorization is signed to make my health information available to the other party (ies) to the lawsuit for use in any stage of the law suit. This may include medical information prior to and/or following the date of this authorization, up until the expiration date of the authorization. The information covered by this authorization may be relevant as my mental or physical condition is in controversy in the lawsuit. A photocopy of this authorization shall be considered as valid as the original.

8. I understand that I may revoke this authorization, except to the extent action has already been taken in reliance upon this authorization, at any time by sending a written revocation to the doctor, hospital, or other custodian of medical information.

9. The recipient of this information identified in paragraph 2 may make further disclosure of this information that may not be subject to the protections set forth in 45 CFR Parts 160 through 164.

_____ _____
PATIENT SIGNATURE DATE OF SIGNATURE

_____ _____
PARENT / LEGAL GUARDIAN SIGNATURE DATE OF SIGNATURE

_____ _____
PERSONAL REPRESENTATIVE (DECEASED PATIENT) DATE OF SIGNATURE

SUBSCRIBED AND SWORN BEFORE ME

THIS _____ DAY_____20_____

_____

NOTARY PUBLIC, _____COUNTY

MY COMMISSION EXPIRES:_____