Original - Records custodian
1st copy - Court

2nd copy - Requesting party
3rd copy - Patient
JIS CODE: AFR

Approved, SCAO

STATE OF MICHIGAN JUDICIAL DISTRICT JUDICIAL CIRCUIT COUNTY PROBATE	AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION	CASE NO.

Court address

Court telephone no.

Plaintiff	v	Defendant

☐ Probate In the matter of _____

AUTHORIZATION

1. _____ _____ _____
Patient's name | Social security no. | Date of birth

2. I authorize _____
Name and address of doctor, hospital, or other custodian of medical information

to release _____
Description of medical information to be released (include dates where appropriate)

to _____
Name and address of party to whom the information is to be given

3. I understand that unless I expressly direct otherwise:

a) the custodian will make the medical information reasonably available for inspection and copying, or
b) the custodian will deliver to the requesting party the original information or a true and exact copy of the original information accompanied by the certificate on the reverse side of this authorization.

I understand that medical information may include records, if any, on alcohol and drug abuse, psychology, social work, and information about HIV, AIDS, ARC, and any other communicable disease.

4. This authorization is made in accordance with Michigan Court Rules and is valid for : ☐ six months after being signed.
☐ will expire on _____ . ☐ upon _____.
Date | happening of a specific event

This authorization is signed to make medical information regarding me available to the other party(ies) to the lawsuit listed above for their use in any stage of the lawsuit. The medical information covered by this release is relevant because my mental or physical condition is in controversy in the lawsuit.

5. I understand that by signing this authorization there is potential for protected health information to be redisclosed by the recipient.

6. 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.

_____
Date

_____ _____
Signature | Address

_____ _____
Name (type or print) (If signing as Personal Representative, please state under what authority you are acting) | City, state, zip | Telephone no.

45 CFR 164.508, MCL 333.5131(5)(d), MCR 2.506(I)(1)(b), MCR 2.314