LCS Job No.

Legal Copy Services

3280 N. Evergreen Drive NE / Grand Rapids, MI 49525-9580
Phone: (877) 949-1313 / Fax: (877) 949-2270
www.legalcopyservices.com

HIPAA COMPLIANT 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, to **Legal Copy Services, Inc.,** an agent of the receiving party(ies):

Employer: _____

_____

_____

A description of the information to be released:

3. I understand that unless I expressly direct otherwise:

a) the custodian will make the medical or other information reasonably available for inspection and copying, or,
b) the custodian will 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 certificate.

I understand that information requested includes all information in my file, included 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 records on alcohol and drug abuse, psychology, social work, and information about HIV, AIDS, ARC, and any other communicable disease.

4. This authorization is valid for twelve months and is signed to make medical or other information regarding me available to the other party(ies) to the lawsuit for their use in any stage of the lawsuit. The medical or other 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 sending a written revocation to the doctor, hospital, or other custodian of medical or other information.

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

_____
DATE

_____
SIGNATURE

_____
NAME (type or print) If signing as Personal Representative, please state under what authority you are acting.

_____
ADDRESS

_____
CITY, STATE, ZIP