Approved, SCAO

Original - Records custodian
1st copy - Requesting party
2nd copy - Patient

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 _____

1. _____ _____
Patient's name Date of birth

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

to release SEE SUBPOENA - Records from DOB (___-___-_____) to present. OR ___-___-_____ to ___-___-_____
Description of medical information to be released (include dates where appropriate)

to CD SERVICES INC. 24027 Research Drive Farmington Hills, MI 48335 (records@ cdservicesinc.com 248-476-1700)
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 valid for 60 days and 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

CERTIFICATE

1. I am the custodian of medical information for _____ .
   Organization
2. I received the attached authorization for release of medical information on _____ .
   Date
3. I have examined the original medical information regarding this patient and have attached a true and complete copy of the information that was described in the authorization.
4. This certificate is made in accordance with Michigan Court Rule.

I declare that the statements above are true to the best of my information, knowledge, and belief.

_____
Date

_____
Signature

_____
Name (type or print)

_____
Address

_____
City, state, zip Telephone no.