MINUTE MAN SERVICES, INC.
DIGITAL DOCUMENT SOLUTIONS

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Web: mm.services

AUTHORIZATION FOR RELEASE OF EMPLOYMENT INFORMATION

Facility Name: _____

Facility Address: _____

Name on Record: _____ Maiden/Alias: _____

Name on Record's Address: _____ D.O.B.: _____

_____ S.S.N.: _____

I, _____, authorize you and any current or past employer to release:

TO: MINUTE MAN SERVICES, INC. - 3905 ROCHESTER RD - ROYAL OAK, MI 48073
SECURE EMAIL: REQ@MM.SERVICES

THE INFORMATION BEING SOUGHT IS TO BE USED IN THE EVALUATION OF A PENDING LEGAL SUIT.

Failure to authorize release of this information may cause a delay in the processing of that suit. A photo static copy of this authorization shall serve in its stead.

THIS INFORMATION MAY INCLUDE ALCOHOL AND DRUG ABUSE RECORDS PROTECTED UNDER THE REGULATIONS IN CODE 42 OF FEDERAL REGULATIONS, PART 2, IF ANY, PSYCHOLOGICAL SERVICES RECORDS, IF ANY, AND SOCIAL WORK RECORDS, IF ANY, INCLUDING COMMUNICATIONS MADE BY ME TO A SOCIAL WORKER OR PSYCHOLOGIST.

CONSISTENT WITH MICHIGAN PUBLIC ACT 488 OF 1988, THIS AUTHORIZATION ALSO INCLUDES DISCLOSURE OF ANY INFORMATION IN MY RECORDS PERTAINING TO ANY COMMUNICABLE DISEASES OR INFECTIONS, IF ANY, INCLUDING HIV INFECTION, ACQUIRED IMMUNODEFICIENCY SYNDROME, AIDS RELATED COMPLEX, VENEREAL DISEASE, TUBERCULOSIS, MENINGITIS, GIARDIASIS, HEPATITIS A, B, AND NON A, NON B, HISTOPLASMOSIS, LEGIONNAIRES' DISEASE, SALMONELLOSIS, SHIGELLOSIS AND STAPHYLOCOCCAL INFECTIONS.

MINUTE MAN WILL ONLY USE THIS INFORMATION FOR THE PURPOSES STATED HEREIN, AND WILL NOT DISSEMINATE THE INFORMATION DISCLOSED FOR ANY OTHER PURPOSE. HOWEVER, HIPAA REGULATION 45CFR164.508(C)(2)(III) REQUIRES US TO INFORM YOU THAT THERE IS THE POTENTIAL THAT THE INFORMATION DISCLOSED HERE COULD BE REDISCLOSED AND THAT IT IS POSSIBLE THAT YOU COULD LOSE THE PROTECTIONS OF HIPAA REGULATION 45CFR164.508(C).

THIS AUTHORIZATION IS VALID FOR OR UNTIL THE CLOSE OF LITIGATION (WHICHEVER IS LATER), BUT MAY BE REVOKED UPON WRITTEN REQUEST TO: MINUTE MAN SERVICES, INC. - 3905 ROCHESTER RD - ROYAL OAK, MI 48073, AND/OR FACILITY LISTED ABOVE. RECORDS MAY HAVE ALREADY BEEN RELEASED BASED UPON A PREVIOUS AUTHORIZATION. PATIENT OR AUTHORIZED REPRESENTATIVE SIGNING THIS AUTHORIZATION UNDERSTANDS THAT THIS AUTHORIZATION IS VOLUNTARY AND THEY MAY REFUSE TO SIGN. TREATMENT OR PAYMENT WILL NOT BE CONDITIONED UPON THIS AUTHORIZATION OR REVOCATION OF THIS AUTHORIZATION UNLESS OTHERWISE ALLOWED BY LAW.

SIGNATURE: _____ **DATE:** _____
(PATIENT/PARENT/GUARDIAN/CONSERVATOR/SPOUSE/EMPLOYEE)