



# MINUTE MAN SERVICES, Inc.

DIGITAL DOCUMENT SOLUTIONS

3318 North Main Street Royal Oak, Michigan 48073

Phone: 248-585-6300 - Fax: 248-585-5822

http://www.minutemanservices.net

## AUTHORIZATION FOR RELEASE OF INSURANCE INFORMATION

To: \_\_\_\_\_

Re: \_\_\_\_\_

Policy #: \_\_\_\_\_ D. O. B.: \_\_\_\_\_

Claim #: \_\_\_\_\_ S. S. N.: \_\_\_\_\_

Date of Accident: \_\_\_\_\_ Maiden Name/Alias: \_\_\_\_\_

I, \_\_\_\_\_, authorize any insurance entity to release any and all information, including personal injury protection papers, property damage files, claims information, disability information, application for benefits, color photos, repair estimates, repair bills, medical information, accident investigation reports, incident reports, copies of policies, policy summary plan description, adjusters notes, etc., if any to:

**MINUTE MAN SERVICES, INC. - 3318 N MAIN ST - ROYAL OAK, MI 48073**

**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, LEGIONNAIRE'S DISEASE, SALMONELLOSIS, SHIGELLOSIS AND STAPHYLOCOCCAL INFECTIONS.

**Information obtained with this release may be subject to re-disclosure by the recipient and will no longer be protected by rule 164.508(c) of the HIPAA regulations.**

THIS AUTHORIZATION IS VALID FOR ONE (1) YEAR AFTER IT IS SIGNED, BUT MAY BE REVOKED UPON WRITTEN REQUEST TO: MINUTE MAN SERVICES, INC., - 3318 N MAIN ST - ROYAL OAK, MI 48073, AND/OR FACILITY LISTED ABOVE. RECORDS MAY HAVE ALREADY BEEN RELEASE BASED UPON A PREVIOUS AUTHORIZATION. 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)

Subscribed and sworn to before me this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_  
(1<sup>st</sup>, 2<sup>nd</sup>, 3<sup>rd</sup>) (Month) (Year)

Notary Public, \_\_\_\_\_, \_\_\_\_\_ My commission expires: \_\_\_\_\_  
(County) (State) (Expiration Date)

**NOTARY SIGNATURE:** \_\_\_\_\_, acting in \_\_\_\_\_  
(County)