



# 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 WORKERS' COMPENSATION RECORDS

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

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

Maiden Name/Alias: \_\_\_\_\_ D. O. B.: \_\_\_\_\_

S. S. N.: \_\_\_\_\_

I, \_\_\_\_\_, authorize any entity to release any and all workers' compensation records including medical, employment data, and payments made while on workers' compensation to myself, doctor, nurse, chiropractor, physical therapist, psychologist, mental health provider, etc., inclusive of any payments made to individuals who provided any services or care, whatsoever, 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.

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, HISTOPLASMOVIS, 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: \_\_\_\_\_  
(PATIENT/PARENT/GUARDIAN/CONSERVATOR/SPOUSE/EMPLOYEE)

DATE: \_\_\_\_\_

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)