

AUTHORIZATION FOR RELEASE OF INFORMATION

MCS File 62579-4

Name: _____ SSN: _____ DOB: _____
Address: _____ City: _____ State: _____ Zip Code: _____

I. General Release.

I hereby authorize _____ of _____ [Name and address of record source: e.g., Employer] to disclose the information set forth in Section IV this Authorization for the period from _____ to _____. The released information is required for litigation. I further authorize The MCS Group, Inc., a private record reproduction company, upon presentation of this authorization or a copy thereof, to photocopy such records as are reasonably necessary for the above-state purposes.

II. Health Information Release. I hereby authorize the disclosure of my health information, as described in this authorization:

- a.) Person(s) authorized to disclose the information: _____ [Name of the Provider: Hospital, Doctor, Insurance Co.]
- b.) Information to be disclosed: The Information set forth in Section V of this Authorization. I understand that the health information may include information pertaining to treatment of drug and alcohol abuse, mental health including without limitation psychiatric information, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), sexually transmitted diseases, sick cell anemia treatment, tuberculosis information or genetic information. THIS INFORMATION WILL BE RELEASED UNLESS I INDICATE OTHERWISE BY CHECKING HERE: _____
- c.) Person(s) authorized to receive the disclosed information: The MCS Group, Inc. on behalf of: _____ [Name of MCS Client]
I further authorize The MCS Group, Inc., a private record reproduction company, upon presentation of this authorization or a copy thereof, to photocopy such records as are reasonably necessary for the above-state purposes.
- d.) Purpose of this request: At my request.
- e.) Expiration Date: Unless otherwise revoked, this authorization will expire one year after the date of this authorization or later as indicated here _____
- f.) Right to revoke: I understand that I have the right to revoke this authorization at any time by notifying in writing each Person identified in Section (a). I understand that the revocation is only effective after it is received and logged by such Person. I understand that any disclosure made prior to the revocation under this authorization will not be affected by the revocation.
- g.) Subsequent Disclosure: I understand that any disclosure of information may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.
- h.) Impact on Medical Treatment: I understand that I do not need to sign this authorization to assure any medical treatment. I understand that I may inspect and/or copy the information to be disclosed. I understand that authorizing this disclosure is voluntary. I understand that if I have any questions about disclosure of my health information, I may contact the privacy officer for each Person identified in Section (a).

III. Signature/Certification.

Signature of Person Identified Above or his or her Authorized Representative / Guardian _____ Date _____

By signing this authorization, the Authorized Representative and/or Guardian warrants that he or she has the authority to act on behalf of the person identified above on the basis of: _____