

**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
<input type="checkbox"/> 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 \_\_\_\_\_ Description of medical information to be released (include dates where appropriate) \_\_\_\_\_  
to \_\_\_\_\_ 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. \_\_\_\_\_

**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.

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Date

Signature

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Name (type or print)

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Address

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City, state, zip

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Telephone no.