Axiom Requisition Copy Service

8164 Executive Ct., Lansing, Michigan 48917

517.886.5099 - 877.886.5090 toll free - 517.886.4116 facsimile

AUTHORIZATION FOR RELEASE OF DOCUMENTS CONTAINING HEALTH INFORMATION

TO: Axiom Requisition
Dept. Medical Records
8164 executive
lanisng, MI 48864

RF	EGARDING:							
1.	test	11/01/2019						
	PATIENT'S NAME SOCIAL SECURITY NUMBER	DATE OF BIRTH						
2.	I, the undersigned, hereby authorize the records custodian or the medical records department or the director or designee of the above nam (the "Releasing Party") to release or disclose documents containing health information to Axiom Requisition Copy Service, an agent of Axio Requisition Copy Service (the "Receiving Party").							
3.	This authorization is made in accordance with the federal and state law and is valid for a period of 12 months after being signed or at the conclusion of the legal action of ab vs cd , whichever is later or as follows:							
4.	I understand that I may revoke this authorization at any time by sending a written revocation to Axiom Requisition, except to the extent that it has taken action in reliance on the authorization.							
5.	I understand that once my health information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure or release by the Receiving Party and may no longer be protected by federal or state law.							
6.	A description of the health information I authorize for use or disclosure is: FROM 11/01/2019 TO 11/19/2019: Any and all BILLING RECORDS including but not limited to payments pertaining to test SSN:, DOB: 11/01/2019. All protected health information regarding the individual in your custody which may include information relating to acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), information about behavioral or mental health services, and treatment for alcohol and drug abuse. This request may also include any information regarding communicable diseases and serious communicable diseases and infections, which includes venereal disease, tuberculosis, or ARC, if any, as well as all Genetic Information and Demographic Information for the purposes and Conditions designated on this Form. Such information will be oral and in writing, and should include all notes, consultations, orders, medications, prescriptions, operative reports, pathology reports, pathology slides, x-ray reports, x-rays, graphic records, nurses notes, subjective symptoms, opinions, diagnoses, prognoses, contributing factors, complications, reports, correspondence, photographs, medical records, and any other medical information you may have.							
7.	This authorization for release of my documents containing health information is provided in connection with the legal action referred to above in which allegations of wrongful conduct, damage or loss have been made making the above information discoverable under state law.							
8.	This authorization is voluntary. I understand that my continued or future treatment by or payment to the Releasing Party, enrollment, or eligibility for benefits is not conditioned upon my providing or signing this authorization.							
9.	A photocopy of this consent is as valid as the original.							
10.	I have been provided with a copy of this authorization for my records (initials)							
PA	TIENT SIGNATURE DATE							
PA	RENT / LEGAL GUARDIAN SIGNATURE RELATIONSHIP DATE							
	RSONAL REPRESENTATIVE (DECEASED PATIENT) LEASE INCLUDE LETTER OF AUTHORITY TO ACT FOR THIS	INDIVIDUAL)						
	SUBSCRIBED AND SWORN BEFORE ME							
	THIS, 20	_						
		_						

NOTARY PUBLIC _

MY COMMISSION EXPIRES: _____

Order No. 64228 - 1

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3.	This authorization is made in accordance with the federal and state law and is valid for a period of 12 months after being signed or at the conclusion of the legal action of ab vs cd , whichever is later or as follows:									
4.	I understand that I may revoke this authorization at any time by sending a written revocation to Axiom Requisition, except to the extent that it has taken action in reliance on the authorization.									
5.	understand that once my health information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure or release by the Receiving Party and may no longer be protected by federal or state law.									
6.	A description of the health information I authorize for use or disclosure is: FROM 11/01/2019 TO 11/19/2019: MEDICAL RECORDS and BILLING RECORDS, including but not limited to patient history form(s), reports, payments, etc. pertaining to test SSN: , DOB: 11/01/2019. All protected health information regarding the individual in your custody which may include information relating to acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), information about behavioral or mental health services, and treatment for alcohol and drug abuse. This request may also include any information regarding communicable diseases and serious communicable diseases and infections, which includes venereal disease, tuberculosis, or ARC, if any, as well as all Genetic Information and Demographic Information for the purposes and Conditions designated on this Form. Such information will be oral and in writing, and should include all notes, consultations, orders, medications, prescriptions, operative reports, pathology reports, pathology slides, x-ray reports, x-rays, graphic records, nurses notes, subjective symptoms, opinions, diagnoses, prognoses, contributing factors, complications, reports, correspondence, photographs, medical records, and any other medical information you may have.									
7.		This authorization for release of my documents containing health information is provided in connection with the legal action referred to above in which allegations of wrongful conduct, damage or loss have been made making the above information discoverable under state law.								
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AUTHORIZATION FOR RELEASE OF DOCUMENTS CONTAINING HEALTH INFORMATION

TO	: Axiom - Use for Javier Order to Set-up	o Billing					
	Dept.						
	,						
RE	GARDING:						
1.	test PATIENT'S NAME			OCIAL SEC	URITY NUM	BER	11/01/2019 DATE OF BIRTH
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3.	This authorization is made in accordance with the federal and state law and is valid for a period of 12 months after being signed or at the conclusion of the legal action of ab vs cd , whichever is later or as follows:						
4.	I understand that I may revoke this authorization at any time by sending a written revocation to Axiom - Use for Javier Order to Set-up Bil, except to the extent that it has taken action in reliance on the authorization.						
5.	I understand that once my health information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure or release the Receiving Party and may no longer be protected by federal or state law.						
6.	A description of the health information I authorize for FILMS, including but not limited to patient his information regarding the individual in your syndrome (AIDS), or human immunodeficient treatment for alcohol and drug abuse. This reserious communicable diseases and infections, Genetic Information and Demographic Information will be oral and in writing, and should include pathology reports, pathology slides, x-ray rediagnoses, prognoses, contributing factors, continuing the information you may have.	tory forms, etc. pertacustody which may cy virus (HIV), information includes very which includes very the purpose le all notes, consultaceports, x-rays, grap	ining to testinclude injustmation and independent independent independent independent independent independent independent independent independent incursion inclusion in the incursion inc	st SSN: , _ formation about beha formation ease, tuber ditions des ers, medicals, nurses	DOB: 11/01 relating to vioral or regarding culosis, or ignated on ations, pres notes, sub	72019. Al acquired mental he communic ARC, if a this Form. scriptions, bjective sy.	l protected health immunodeficiency alth services, and table diseases and my, as well as all Such information operative reports mptoms, opinions
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	EASE INCLUDE LETTER OF	AUTHORITY	ТО	ACT	FOR	THIS	INDIVIDUAL
		SUBSCRIE	BED AND SWOR	N BEFORE ME	Σ		
		THIS	DAY C	OF		, 20	_

NOTARY PUBLIC _____COUNTY
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