

**HIPAA Privacy Authorization**  
**For Disclosure of Protected Health Information**  
**Relevant to Litigation, Pending Claims or Intent to Sue**

Patient's Name: Tamara Filas  
Address: 6477 Edgewood, Canton, MI 48187  
Date of Birth: redacted  
Social Security No.: XXX-XX- redacted

1. I make this authorization for the purpose of copying records in connection with a lawsuit or claim to which I am a party.
2. This authorization is directed to and applies to protected health information maintained by:

**Dr. Jon Wardner/Associates in Physical Medicine and Rehabilitation**

(Hospital, Physician, Medical provider, etc.)

3. I hereby authorize the above, its director, administrative and clinical staff or assignees, medical information services and billing department to release any and all medical records and information from my date of birth to the present unless specified otherwise, relating to my care and treatment, including x-rays, photographs, electronic and digital files and any other records, unless I expressly direct or specify otherwise. I understand that medical information may include records, if any, relating to treatment for alcohol and drug abuse protected under the regulations in 42 C.F.R. Part 2; psychiatric/psychological services and social work records and any information regarding communicable diseases and infections, defined by Michigan Department of Public Health rule, which can include tuberculosis, venereal diseases, sexually transmitted diseases, acquire immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV) or ARC.
4. This information is to be released for copying purposes to James C. Wright of ZAUSMER, KAUFMAN, AUGUST & CALDWELL, P.C.
5. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by the Federal Privacy Rules.
6. This authorization shall be in force and in effect until the conclusion of the pending litigation or claim unless otherwise specified.
7. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and send it to the hospital, doctor, or other custodian of medical information. I understand that the revocation will not apply to information that has already been released in response to this authorization.
8. I understand that authorizing the release of this health information is voluntary and that I need not sign this form in order to ensure health care treatment, eligibility for benefits, payment or health plan enrollment.
9. A copy of this authorization is as valid as the original.

**All Pertinent Sections Of This Form Must Be Completed Before Signing**

Subscribed and sworn to before me  
this \_\_\_\_ day of \_\_\_\_\_, 2013

\_\_\_\_\_  
Notary Public  
\_\_\_\_\_  
County, Michigan  
My Commission Expires: \_\_\_\_\_

X \_\_\_\_\_  
Signature of Patient or Legal Representative

\_\_\_\_\_  
Print Name of Patient or Legal Representative

\_\_\_\_\_  
Description of Legal Representative's Authority  
or Relationship