Michigan Property & Casualty Guaranty Association
PO Box 531266 • Livonia, Michigan 48153-1266 • Phone: (248) 482-0381

AUTHORIZATION FOR RELEASE OF RECORDS

Patient/Claimant Name: ____

Date of Birth (00/00/0000): ____

MPCGA Claim No.: ____

Date of Loss (00/00/0000): ____

I authorize any physician, surgeon, dentist, nurse, therapist, hospital, ambulatory surgery center, rehabilitation provider, nursing home, home for the aged, adult foster care facility, home health agency, hospice, behavioral health hospital or partial hospitalization program, outpatient clinic, ambulance company, employer, health insurance carrier, or any other insurance company, including but not limited to the following:

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to furnish to any representative of the MICHIGAN PROPERTY & CASUALTY GUARANTY ASSOCIATION ("the MPCGA"), including its Executive Director, Jeffery D. Jenkins, all health information and records in their possession identifying the above stated patient/claimant, including but not limited to health information and any records relating to any injury, treatment, medical history, physical condition, insurance documents and claim records. The information that can be disclosed includes the following, if any exists relating to the claimant: mental health treatment information, substance use disorder treatment information, HIV/AIDS treatment information, genetic testing information, communications with a social worker, information about communicable and sexually transmitted diseases, and all substance abuse treatment information. I understand that upon my written request, I have the right to receive a list of entities to which my information has been disclosed pursuant to this release. I further authorize the release of any assignment of rights entered into between myself and any other person or entity.

This information will be used for the purpose of verification, evaluation, and negotiation of the Claimant's insurance claim with MPCGA and other legal uses relating to that claim.

This authorization expires when the Patient/Claimant's claim for insurance benefits from MPCGA is finally adjudicated and closed.

You have the right to revoke this authorization at any time. The only exception is if the authorized entities have already acted in reliance upon the authorization. If you want to revoke your authorization, send us a written note telling us that your authorization is revoked. Send this note to the address listed at the top of this form.

It is completely your decision whether or not to sign this authorization form. The Organization or person named in this authorization cannot refuse to treat you just because you choose not to sign.

With the exception of substance use disorder treatment information, mental health information or HIV/AIDS information, MPCGA may have no legal duty to further protect the confidentiality of your health information. In some cases, MPCGA may re-disclose the information as it wishes.

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AND RECORDS AS DESCRIBED IN THIS FORM.

________________________________ ________________
Patient/Claimant Signature Date (00/00/0000)

________________________________ ________________
Personal Representative Signature Date (00/00/0000)

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Nature of Representation