UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF MICHIGAN
SOUTHERN DIVISION

In Re Flint Water Cases

No. 5:16-cv-10444-JEL-MKM

HON. JUDITH E. LEVY

MAG. MONA K. MAJZOUB

EXHIBIT 11.6

AUTHORIZATION FOR RELEASE OF MEDICAL/PSYCHIATRIC RECORDS

Name of Medical Care Provider/Hospital:

Name of Patient:

Date of Birth: Social Security No.:

I, _____, hereby authorize the Custodian of Records of the above referenced entity to release protected health information, including any and all information which may be requested regarding my past or present physical, emotional, or psychological condition, injuries, or disease, regarding which I have consulted you or received your services, including, but not limited to, the nature of any impairment, history, contributing factors, complications, prescriptions, x-rays, testing, notes, hospital records, medical or psychiatric records, behavioral medicine services records, including communications made by me to a social worker or psychologist, unredacted progress notes, period of disability, subjective symptoms, prognosis, statement of charges, alcohol and drug abuse records protected under the regulations in Title 42 Code of Federal Regulations, Part 2, any information regarding communicable diseases and infections as defined by MCL 333.5131, including venereal diseases, tuberculosis, HIV, AIDS, and ARC, and any further information which may be available to you. This authorization is made pursuant to HIPAA.

Disclosure is made to:

ATTORNEYS: _____

The purpose and need for disclosure is for all purposes allowable under the law. The information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by HIPAA.

This authorization is for copying purposes only, and does not authorize *ex parte* communication.

This authorization is valid for the duration of the lawsuit, _____, _____ Court Case No. _____.

I may revoke this authorization in writing in accordance with the Privacy Notice of the medical care provider or hospital identified above.

A PHOTOCOPY OF THIS DOCUMENT SHALL BE CONSIDERED VALID AS IF THE ORIGINAL WERE OFFERED.

Dated: _____ _____

[Patient Name]