AUTHORIZATION TO RELEASE RECORDS AND INFORMATION

Name: ____

Address: ____

____

Social Security Number: ____

Date of Birth: ____

For purposes of this Authorization to Release Records and Information ("Authorization"), UCS shall mean **UNIVERSAL CREDIT SERVICES, INC.,** and its affiliated entities, parent companies, subsidiaries, employees, owners, officers, members, managers, partners, shareholders, directors, assignees, attorneys, agents, independent contractors, insurers, clients, and persons or entities acting or purporting to act for it, or on its behalf, or on behalf of any of the above-named parties.

1. **Authorization.** I authorize UCS to give, disclose, and release to any one or more of my agents named in Paragraph 2 below, without restriction, any non-public personal information regarding me, if any, in the possession of UCS. Such information may include personal financial information or individually identifiable health information, medical records, and other information regarding my past, present, or possible future medical, dental, or other health condition or diagnosis, including reproductive health, mental illness, drug or alcohol abuse, and the billing or payment for such diagnosis and treatment (collectively, "Information"). This Authorization shall be interpreted as broadly as possible to include disclosure of all Information to my agent(s) and discussion of all matters with them that could be discussed with me personally. The authority given to my agent(s) under this Authorization shall supersede any prior agreement that I may have made to restrict access to or disclose my personal financial information or individually identifiable health information, if any.

2. **Persons Authorized to Receive Information.** The Information may be released, provided to, or discussed with any of the following persons or entities, who are my agent(s) for this purpose:

Name: ____

Company: ____

Address: ____

Telephone: ____

Facsimile: ____

E-mail: ____

3. **When and how to provide Information.** UCS is authorized to provide Information at any time, and from time to time, at the request of any one or more of the individuals or companies identified in Paragraph 2 above. It may be provided by direct in-person discussion, or by e-mail, telephone, fax, or any other type of communication. UCS may assume that whoever is communicating with UCS by telephone, e-mail, fax, or other type of communication is the person as represented by that individual.

4. **Authority to revoke.** I may revoke this Authorization for any reason. I understand that to revoke this Authorization, the notification must be written, signed by me, and dated ("Written Notification of Revocation"), and will become effective upon receipt by UCS.

5. **Expiration.** This Authorization shall remain valid until such time as UCS: (i) has satisfactorily resolved all matters concerning me referred or assigned to UCS for resolution (regardless of source); (ii) received my Written Notification of Revocation; or (iii) has been directed, by a Court or other authority, through subpoena, order, or otherwise, to disclose my Information.

6. **Redisclosure.** I understand that the Information disclosed under this Authorization may be subject to redisclosure by the recipient and therefore may no longer be protected under state or federal law.

7. **Photostatic copies.** A photostatic copy of this Authorization shall be considered as effective and valid as the original.

8. **Voluntary action.** I understand that I am not required to sign this Authorization, and I am signing this document voluntarily.

9. **Privacy waiver.** With regard to the disclosure of information authorized in this document, I waive any right of privacy that I may have under the authority of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191, that might otherwise prevent any person or entity to whom this release is delivered from providing access to my medical records or other information authorized to be released under this document, and I hold harmless from any claim of liability under such act, rule, or regulation any person or entity who provides information or access to my medical information and records under this Authorization.

10. **Durable power.** This Authorization shall not be affected by my disability. The authority of my agent(s) shall be exercisable notwithstanding my later disability or incapacity or later uncertainty as to whether I am alive.

Dated: ____________ ____________________________________

Signature

____

Printed Name

Please return completed form to:

UCS, P.O. Box 158, Hartland, MI 48353-0158 or **ucs@ucscollections.com**