



Health Information Management
 Release of Information Unit
 2901 Hubbard Rd #2722
 Ann Arbor, Michigan 48109-2435
 Phone: (734) 936-5490
 Fax: (734) 936-8571

AUTHORIZATION TO RELEASE PATIENT INFORMATION

(Patient Requests Information To Be Sent From UMHS)

For Office Use Only:

Information:

Mailed Picked Up Faxed
ID Verified: Yes No
Supporting Info Rec'd: Yes No

Request Processed By:

HIM Staff Other: _____

This authorization is voluntary. I understand that UMHS will not condition treatment, payment, enrollment, or eligibility for benefits on my signing this document. A separate form is required for release of psychotherapy (process) notes.

Patient Name: _____ **Date of Birth:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Telephone #: _____ **Registration Number:** _____

1. I am the patient listed above or the legally authorized representative of the patient listed above. I request the University of Michigan Health System to release my protected health information (or the information of the patient listed above) to:

- Myself
- Name of Person/Organization: _____
 Street Address: _____
 City/State/Zip: _____

2. Specific Information to be Released From Date: _____ **To Date:** _____

I request the following information to be released, which may include *alcohol and drug abuse/treatment; psychological and social work counseling; HIV or AIDS or ARC; communicable disease or infections, including sexually transmitted diseases, venereal disease, tuberculosis and hepatitis, and demographic information, for the purposes and conditions designated on this form.*

- Pertinent Package (Discharge Summary, Operative Report, Consults, Labs and Radiology Reports)
- Inpatient Record X-Ray- Imaging Reports Laboratory Tests/Results Emergency Room Record
- Outpatient Record X-Ray- Imaging Films/CD Billing Record Entire Medical Record
- Pathology Other (specify): _____

3. Purpose of Release/Disclosure:

- At the request of the patient (or patient's legally authorized representative); *or*
- At the request of someone other than the patient for the following purpose(s):
 - Attorney/Legal Social Security/Disability Certification
 - Insurance Worker's Compensation
 - Research (specify institution and IRB #): _____
 - Other (specify): _____

4. This authorization expires on: _____ *(specify expiration date or event).*
If left blank, the authorization will expire six (6) months after the date signed below.

5. Revoking authorization: I may revoke this authorization at any time. Revocations must be made in writing and sent to the UMHS Health Information Management department. Revocations will not apply to information that already has been released. If this authorization was obtained as a condition of providing insurance coverage, the authorization will not apply to my insurance company to the extent the law provides my insurer with the right to contest a claim under the policy, or the policy itself.

6. Effect of release: Once information has been disclosed, UMHS can no longer protect it from further disclosure.

SIGNATURE: _____ **DATE:** _____

NAME (printed): _____

Relationship to Patient: Parent Legal Guardian Other (proof of legal authority may be required)

POD-138	Rev: 6/07 HIM: 6/07	IMAGED DOCUMENTS ADMINISTRATIVE (ROI) RELEASE OF INFORMATION FROM MEDICAL RECORD		AUTHORIZATION TO RELEASE PATIENT INFORMATION
---------	------------------------	---	--	--

**HOW TO OBTAIN COPIES OF MEDICAL RECORDS
AUTHORIZATION FOR RELEASE OF INFORMATION (ROI)**

Records can be released to anyone that the patient authorizes (in writing) to receive such information. **A valid authorization MUST contain the following information or the request will be returned:**

1. Patient's full name and date of birth (list any other names the patient may have had).
2. Hospital registration number (if available);
3. Specific information being requested (e.g. type of report/information and dates of service, etc.);
4. Purpose for which the information may be disclosed;
5. To whom the information is to be sent (name and address);
6. Specify authorization's expiration date if desired (see ROI form);
7. The patient's signature or a patient's legal representative's signature. Authorizations signed by a representative must contain a copy of the guardianship papers or power of attorney;
8. Date of the signature.

Requests for medical records of *deceased patients* require a letter of authority in addition to your signed request. The letter of authority is given to the executor of a person's estate by the Probate Court upon their death. Releasing records to anyone other than the executor is illegal, as stated in Michigan Court Law 600.2157. Please also include your phone number in case we need to contact you for additional information concerning your request.

SUBMITTING REQUESTS & RECEIVING RECORD COPIES

Requests for medical records may be mailed or faxed to Health Information Management-Release of Information (2901 Hubbard Rd., Rm 2722, Ann Arbor, MI 48109-2435, fax 734-936-8571). Records will be sent through US Mail. Records needed for medical emergencies will be faxed directly to a physician or medical facility. Our average turnaround time for processing requests is 7 business days.

SENSITIVE INFORMATION

Certain information requires a special authorization covering sensitive information. This includes ***psychiatric, drug and/or alcohol abuse, HIV/AIDS, and sexual abuse information***. Authorizations for sensitive information must specifically refer to the information that is to be released. SENSITIVE INFORMATION IS NEVER FAXED, PER HOSPITAL POLICY and protection of your privacy.


FEES

For continuation of care, a "pertinent packet" of your medical information will be sent free of charge. The pertinent packet consists of recent discharge or clinic summaries, letters, procedure notes and diagnostic testing results. Records requested for reasons other than continuing medical care are assessed fees as follows:

- Patients may receive up to 30 pages for FREE and are charged \$1.08 per page for pages 31-50, \$.54 for pages 51-80, and \$.22 for pages 81 and up.
- Attorneys are charged a \$21.58 clerical fee and \$1.08 for each page 1-20, \$.54 for each page 21-50, and \$.22 for each page 51 and over, \$1.39 per page for microfiche copies.
- Insurance companies are charged \$35.00 for pages 1-5; \$50.00 for pages 6-30; and \$65.00 for pages 31-50. For 51 pages or more, they are charged a flat fee of \$65.00 plus \$.75 for each page, \$1.39 per page for microfiche.

Some records requested for legal, insurance, or personal use may require a prepayment. If your request requires pre-payment, a fee notice will be sent to you upon receipt of your request. Actual postage and Michigan State tax will be added. **Checks for copying must be made out to HealthPort.**

**Should you have any questions regarding requests for medical record copies please contact
Release of Information at 734-936-5490.**

POD-138	Rev: 6/07 HIM: 6/07	IMAGED DOCUMENTS ADMINISTRATIVE (ROI) RELEASE OF INFORMATION FROM MEDICAL RECORD		AUTHORIZATION TO RELEASE PATIENT INFORMATION
---------	------------------------------	---	---	---