



Health Information Management  
 Release of Information Unit  
 2901 Hubbard Rd #2722  
 Ann Arbor, Michigan 48109-2435  
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# AUTHORIZATION TO REQUEST PATIENT INFORMATION FROM ANOTHER ORGANIZATION

*(Request for Outside Records)*

<b>For Office Use Only:</b>
Request sent : _____ <input type="checkbox"/> Mailed <input type="checkbox"/> Faxed
Information rec'd: <input type="checkbox"/> Yes <input type="checkbox"/> No Date rec'd : _____
Request Processed By: <input type="checkbox"/> HIM Staff <input type="checkbox"/> 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 #:** \_\_\_\_\_

**1. I hereby authorize the release of information from:**

Name of Person/Organization: \_\_\_\_\_

Street Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

**To: Doctor/Clinic:** \_\_\_\_\_

**1500 E. Medical Center Drive**  
**Ann Arbor, MI 48109**

**2. Specific Information Needed: 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, it may no longer be protected from further disclosure by federal or state privacy laws.

**SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**NAME (printed):** \_\_\_\_\_  
 Relationship to Patient:  Parent  Legal Guardian  Other (proof of legal authority may be required)

POD-139	Rev: 06/07 HIM: 06/07	IMAGED DOCUMENTS ADMINISTRATIVE REQUEST FOR OUTSIDE INFORMATION		AUTHORIZATION TO REQUEST PATIENT INFORMATION FROM ANOTHER ORGANIZATION
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