



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

**UNIVERSITY OF MICHIGAN HEALTH SYSTEM
 AUTHORIZATION TO RELEASE
 PATIENT INFORMATION**

I AUTHORIZE THE UNIVERSITY OF MICHIGAN HEALTH SYSTEM, ITS AGENTS AND ITS EMPLOYEES (UMHS) TO RELEASE PROTECTED HEALTH INFORMATION ABOUT ME / MY CHILD TO THE RECIPIENT 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 UNDER THE CONDITIONS DESIGNATED ON THIS FORM.

PATIENT:

Patient's Name _____ UMHS Registration Number _____

Patient's Address _____

City, State, Zip Code _____

Patient's Date of Birth _____ Phone Number _____

RECIPIENT:

Self or Name of Physician, Institution, Clinic, Etc. _____

Address _____

Suite _____

City, State, Zip Code _____

INFORMATION TO BE DISCLOSED:

- Psychotherapy Notes From _____ to _____
NOTE: Disclosure of Psychotherapy Notes requires a separate authorization form.
- Outpatient Reports From _____ to _____
- Inpatient Reports From _____ to _____
- Radiology Reports From _____ to _____
- Laboratory Tests From _____ to _____
- Specific Records From Specific Dates (Give Dates) _____
- All of the above information
- Billing information From _____ to _____

PURPOSE (S) FOR WHICH THE INFORMATION MAY BE DISCLOSED:

- At the Request of the Patient
- Continuation of Care/Consultation
- Social Security/Disability Certification
- Insurance Claim/Application
- Attorney Inquiry/Legal Matter
- Worker's Compensation
- Other: (specify) _____
- VIEW ONLY – ELECTRONIC
 (DOCUMENTS WILL NOT BE PRINTED OR MAILED)

TO OBTAIN PATIENT INFORMATION FROM ANOTHER HEALTH ORGANIZATION:

- I authorize release of information from: _____
 Name of Physician, Institution, Clinic, etc. _____
 Address _____
 City, State, Zip Code _____

Please send information requested to (please PRINT CLEARLY):

Dr.: _____
 Dept./Clinic _____ Box # _____
 University of Michigan Health System
 1500 East Medical Center Drive
 Ann Arbor, Michigan 48109

EXPIRATION (may be a specific date or a condition; if left blank, expires 6 months from date below):

This authorization expires _____

REVOCAION, REDISCLOSURE, AND CONDITIONING OF ELIGIBILITY:

REVOCAION: I understand that I may revoke my authorization by writing to University of Michigan Health System (Release of Information, 2901 Hubbard Rd, Ann Arbor, Michigan 48109-2435). After it is revoked, UMHS will make no further disclosures to the above persons without a new authorization. UMHS can rely on this authorization until it is revoked, or until the expiration date or conditions are met. A request to revoke my authorization will not apply to the extent UMHS has taken action in reliance upon my authorization. In the event that the authorization was obtained as a condition of providing insurance coverage, the authorization will not apply to my insurance company to the extent that the law provides my insurer with the right to contest a claim under the policy, or the policy itself. **REDISCLOSURE:** Once information has been disclosed, it may no longer be protected from further disclosures by federal or state privacy laws. **CONDITIONING OF ELIGIBILITY:** UMHS will not condition treatment, payment, enrollment, or benefit eligibility on my signing this document.

SIGNATURE: _____

(Patient, Parent, Legal Representative)

DATE: _____

AUTHORIZATIONS SIGNED BY A LEGAL REPRESENTATIVE MUST INCLUDE A COPY OF THE GUARDIANSHIP PAPERS OR A POWER OF ATTORNEY

CN-2040190/244 Rev. 7/06

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 to you via the US Mail. 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 \$1.06 per page for pages 31-50, \$.53 for pages 51-80 and \$.22 for pages 81 and up.
- Attorneys are charged a \$21.20 clerical fee and \$1.06 for each page 1-20, \$.53 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 prepayment, 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 ChartOne.**

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