UNIVERSITY OF MICHIGAN HOSPITALS & HEALTH CENTERS

REQUEST FOR OUTSIDE RECORDS - PATIENT INFORMATION FROM ANOTHER ORGANIZATION

(Authorization to Request)

For Clinic Use Only:

Date Request Sent: _____

☐ Mailed ☐ Faxed

Sent by: _____

Name Title Clinic/Unit

Information Received:

☐ No ☐ Yes - **Date Received:** _____

Received by:

_____

Name Title Clinic/Unit

This authorization is voluntary. I understand that University of Michigan Health System (UMHS) will not condition treatment, payment, enrollment, or eligibility for benefits on my signing this document.

Patient Name:_____ **Maiden/AKA:**_____ **Date of Birth:**_____

Street Address:_____ **UMHS MRN:**_____

City/State/Zip:_____ **Telephone #:**_____

Email Address:_____

1. I hereby authorize the release of information from following Doctor / Clinic / Unit:

Name of Person/Organization: _____

Street Address: _____

City/State/Zip: _____

Send information to:

UMHS Doctor / Clinic / Unit: **FASD Clinic**

ATTENTION (Name): _____ Phone #: **734-232-1530**

Address: **D2204 MPB, Box 5718, 1500 E. Medical Center Dr.** Fax #: **734-936-6897**

City/State/Zip **Ann Arbor, MI 48109-5718**

2. Specific Information Needed: From Dates of Service: _____/_____/_____ to _____/_____/_____
(mm/dd/yyyy) (mm/dd/yyyy)

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.*

☐ Inpatient Record	☐ Consults	☐ Emergency Room Record	☐ Pathology
☐ Outpatient Record	☐ Treatment Summary	☐ Entire Medical Record	☐ X-Ray - Imaging Films/CD
☐ Operative Report	☐ Discharge Summary	☐ Laboratory Tests Results	☐ X-Ray - Imaging Reports

☑ Other (*specify*): _____

3. Purpose of Release/Disclosure: At the request of the patient (or patient's legally authorized representative); *for continuing care.*

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 (cancel) this authorization at any time. Revocations (cancellations) must be made in writing and sent to the releasing organization. Revocations will not apply to information that already has been released.

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 of Patient or Legally Authorized Representative (if patient is a minor or unable to sign) **DATE** (mm/dd/yyyy)

_____

Printed Name of Legally Authorized Representative (if patient is a minor or unable to sign)

Relationship to Patient: ☐ **Spouse** ☐ **Parent** ☐ **Next-of-Kin** ☐ **Legal Guardian** ☐ **DPOA for Healthcare**