

Date Request Sent: _____

Mailed Faxed

Sent by: _____
 Name Title Clinic/Unit

Information Received:

No Yes - Date Received: _____

Received by: _____
 Name Title Clinic/Unit

REQUEST FOR OUTSIDE RECORDS - PATIENT INFORMATION FROM ANOTHER ORGANIZATION
(Authorization to Request)

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: _____
 ATTENTION (Name): _____ Phone #: _____
 Address: _____ Fax #: _____
 City/State/Zip _____

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