Welcome to a quick tutorial for how to fill out a Release of Information form. You can find an example of a filled Release form on page 4. If you have any further questions after reading through this tutorial, please don't hesitate to contact our office by phone (734-998-2150) or email (genderservices@med.umich.edu).

Header:

University of Michigan Health System 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 For Clinical Communication**	MRN: NAME: BIRTHDATE: CSN:

On the right side of the document's header is a box for some identifying data. Please fill in your **legal name** and **birthdate**. If you are sure that you know your MRN or CSN, you can fill them in as well, but we can do so once you send it to us.

You can also see that there is a fax number on the left side of the header. Please **DO NOT** send your ROI to this number. Instead send the document to the Comprehensive Gender Services Program.

Section 1:

1. This authorization is voluntary. I understand that the University of Michigan Health System (UMHS) will not base 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:____

This section of the document requires you to fill in more information about yourself. Please note that "**Patient Name"** needs to be filled in with your **full legal name**. You can include your **preferred name** on the line labeled "**Maiden/AKA"**.

Please include your **contact information** on this document and fill in your **date of birth** as it will help identify you. Once again, if you do not know your MRN, you do not need to fill it in here. We can take care of that step.

Section 2:

2. I am the patient, or the legally authorized representative of the patient, listed above. I hereby authorize clinical communication: From UMHS (Doctor/Clinic/Unit): Stephen Rassi, PhD, LMSW or Sara Wiener, LMSW

To communicate clinical information with the following individual(s)/person(s)/ company(ies)/organization(s):

If the line next to **"From UMHS"** is left blank, please fill it in with "Stephen Rassi PhD, LMSW or Sara Wiener LMSW" as is shown in the above picture.

The empty box is where you will write the **name(s) of the mental health provider(s) who have written or will write your letters of support**. This will need to be their full name(s) not just the clinic/organization/group that they belong to. Even if the ROI is for multiple people at the same office, we will still require that their names are included.

Section 3:

3. Specific Information Needed: From Dates: ____/____/__________ (mm/dd/yyyy) **to** 12 / 31 / 2019 (mm/dd/yyyy).
I request the following information be released, which may include: alcohol and drug abuse/treatment; psychological and social work counseling; HIV, AIDS or ARC; communicable disease or infections, including sexually transmitted diseases, venereal disease, tuberculosis and hepatitis; genetic information and demographic information, for the purposes and conditions designated on this form.

- ☑ Pertinent Medical Information (Discharge Planning, Educational Evaluation, Consults, School program Planning)
- ☑ Progress Reports
- ☐ Report Cards
- ☑ Social Work Reports
- ☑ Relevant Medical History
- ☐ Individual Educational Planning Committee (IEPC) Reports
- ☑ Psychological/Neuropsychological Evaluations
- ☐ Speech / Language Evaluations
- ☑ Test Reports
- ☐ Verbal feedback to and from home-school district personnel
- ☑ Other (specify): **Verbal communication in both directions**

The **first date in the range** should be filled in with your date of birth. The **second date in the range** should be at least a year in the future, if it is not already filled in.

The following list of boxes should be checked off as shown in the above image. This list is as follows:

- Pertinent Medical Information
- Progress Reports
- Social Work Reports
- Relevant Medical History
- Psychological/Neuropsychological Evaluation
- Test Reports
- Other: "Verbal communication in both directions"

Section 4:

4. 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 Insurance Company
  - ☐ Social Security / Disability Certification
  - ☐ Insurance Company
  - ☐ Worker's Compensation
  - ☐ School Requirement
  - ☐ Vocational Rehabilitation
  - ☐ Research (specify institution and IRB#): ____________________
  - ☐ Other (specify): ____________________

The only box that needs to be checked in Section 4 is the one labeled **"At the request of the patient (or patient's legally authorized representative)"**

Sections 5, 6, & 7:

5. This authorization expires on: ______ 12/31/2019 ______ **(specify expiration date or event).**
If the expiration date is left blank, the authorization expires 6 months from the signature date.

6. Revoking (cancelling) authorization: I may revoke (cancel) this authorization at any time. Revocations (cancellations) **must be made in writing** and sent to the UMHS Health Information Management Release of Information Unit at the address listed on this form. Revocations (cancellations) 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.

7. Note: Once information has been disclosed, UMHS can no longer protect it from further disclosure.

If this date is not already filled in, please write the same date as that in the second position of the date range in Section 3.

Sections 6 and 7 are purely informational.

Signature:

______________________________ ____/____/________
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** ☐ **Other (specify):**________

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70-10072	VER: A/15 HIM: 08/15	Medical Record	M	Access / Communication Authorization

You must sign this document physically, pen-to-paper, or we will not be able to use it. Please make sure you **sign your legal name**. You do not need to print your name on the line below your signature.

You only use the line below the signature to print the name of an individual (your Legally Authorized Representative) who is signing the form on your behalf. If you do need to use this line, make sure to check one of the boxes below the line to signify the signer's relationship to the you.

You can find an example of a filled Release form on page 4.

To return this document to us:

- Scan the document back onto your computer and email it to us as a PDF file. We cannot accept a photograph (file extensions such as JPG or PNG) of the document. **It must be a scanned PDF.**
  genderservices@med.umich.edu
- Fax the document to us.
  (734) 998-2152
- Mail the document to us.
  Comprehensive Gender Service Program
  2025 Traverwood Suite A1, Ann Arbor, MI, 48105

University of Michigan Health System
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 For Clinical Communication

MRN: OK TO LEAVE BLANK
NAME: LEGAL NAME
BIRTHDATE: DOB
OK TO LEAVE BLANK

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

Patient Name: LEGAL FULL NAME Maiden/AKA: PREFERRED FULL NAME Date of Birth: DOB
Street Address: YOUR STREET ADDRESS UMHS MRN: OK TO LEAVE BLANK
City/State/Zip: YOUR CITY, STATE, ZIP Telephone #: PREFERRED NUMBER
Email Address: PREFERRED EMAIL ADDRESS

2. **I am the patient, or the legally authorized representative of the patient, listed above. I hereby authorize clinical communication:** From UMHS (Doctor/Clinic/Unit): Stephen Rassi, PhD, LMSW or Sara Wiener, LMSW
To communicate clinical information with the following individual(s)/person(s)/ company(ies)/organization(s):

YOUR MENTAL HEALTH CLINICIAN'S FULL NAME

3. **Specific Information Needed: From Dates:** __/__/ DOB (mm/dd/yyyy) **to** 12 / 31 / 2019 (mm/dd/yyyy).
I request the following information be released, which may include: alcohol and drug abuse/treatment; psychological and social work counseling; HIV, AIDS or ARC; communicable disease or infections, including sexually transmitted diseases, venereal disease, tuberculosis and hepatitis; genetic information and demographic information, for the purposes and conditions designated on this form.
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- ☐ Report Cards
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- ☑ Relevant Medical History
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4. **Purpose of Release / Disclosure:**
- ☑ At the request of the patient (or patient's legally authorized representative); or
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  - ☐ Attorney / Legal Insurance Company
  - ☐ Social Security / Disability Certification
  - ☐ Insurance Company
  - ☐ Worker's Compensation
  - ☐ School Requirement
  - ☐ Vocational Rehabilitation
  - ☐ Research (specify institution and IRB#): ________
  - ☐ Other (specify): ________

5. **This authorization expires on:** 12/31/2019 **(specify expiration date or event). If the expiration date is left blank, the authorization expires 6 months from the signature date.**

6. **Revoking (cancelling) authorization:** I may revoke (cancel) this authorization at any time. Revocations (cancellations) **must be made in writing** and sent to the UMHS Health Information Management Release of Information Unit at the address listed on this form. Revocations (cancellations) 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.

7. **Note:** Once information has been disclosed, UMHS can no longer protect it from further disclosure.

Your Signed Legal Name
Signature of Patient or Legally Authorized Representative (if patient is a minor or unable to sign)

Date You Signed
DATE (mm/dd/yyyy)

OK TO LEAVE BLANK
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** ☐ **Other (specify):** ________

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