



University of Michigan  
 Main Radiology UHB1D240  
 1500 E. Medical Center DR  
 Ann Arbor, MI 48109-0030  
 ph 734-936-4517  
 fax 734-936-8280

# AUTHORIZATION TO RELEASE PATIENT INFORMATION

*(Patient Requests Information To Be Sent From UMHS)*

**For Office Use Only:**

**Information:**

Mailed  Picked Up  Faxed  
**ID Verified:**  Yes  No  
**Supporting Info Rec'd:**  Yes  No

**Request Processed By:**

HIM Staff  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 Number:** \_\_\_\_\_

**1. I am the patient listed above or the legally authorized representative of the patient listed above. I request the University of Michigan Health System to release my protected health information (or the information of the patient listed above) to:**

- Myself
- Name of Person/Organization: \_\_\_\_\_  
 Street Address: \_\_\_\_\_  
 City/State/Zip: \_\_\_\_\_

**2. Specific Information to be Released 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, UMHS can no longer protect it from further disclosure.

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

**NAME (printed):** \_\_\_\_\_

Relationship to Patient:  Parent  Legal Guardian  Other (proof of legal authority may be required)