## MICHIGAN MEDICINE

## REQUEST FOR OUTSIDE RECORDS - PATIENT INFORMATION FROM ANOTHER ORGANIZATION

(Authorization to Request)

For C	linic Use Only:	
Date Request Sent:		
☐ Mailed ☐ Faxed		
Sent by:		
Name	Title	Clinic/Unit
Information Received:		
□ No □ Yes - Date R	eceived:	
Received by:		
Name	Title	Clinic/Unit

						Clinic/Un
	horization is voluntary y for benefits on my si	o. I understand that Michigan gning this document.	Medicine (M	M) will not conditio	n treatment, paymei	nt, enrollment, o
Patient N	Name:	Maide	n/AKA:		Date of Birth:	
Street Address:			UMHS MRN:			
City/Stat	e/Zip:			Telephone #: _		
Email Ad	ldress:					
1. I he	ereby authorize the	release of information fron	n following	Doctor / Clinic / U	J <b>nit:</b>	
Na	me of Person/Organizat	ion:				
Str	reet Address:					
Cit	ty/State/Zip:					
Of	fice Phone #:			Fax #:		
Se	nd information to:					
UN	MHS Doctor / Clinic / U	J <b>nit:</b>				
ΑΊ	TTENTION (Name):			Phone #:		
Ad	ldress:					
Cit	ty/State/Zip					
UN	MHS Doctor / Clinic / U	J <b>nit:</b>				
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Medical Record



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