

MICHIGAN MEDICINE Authorization to Allow Electronic Access to my Electronic Health Record (EHR)	*Michigan Medicine MRN: *PATIENT NAME: *BIRTHDATE:
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- Authorization and Purpose:** I authorize or give permission for the Organization named below, and its physicians/staff as deemed appropriate to view/access my medical records stored electronically at the Michigan Medicine (MM) for the purpose of my continued medical treatment. **I understand that I am not required to sign this authorization**, and both the Michigan Medicine and the Organization named below will not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this document.
- Health information accessed:** I understand that this authorization is for read-only access to my medical records maintained electronically by Michigan Medicine, which may include my medical records from other physicians, hospitals and clinics outside of Michigan Medicine, and 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 designated on this authorization.

The patient signed authorization will be maintained in the Michigan Medicine electronic health record (EHR). **Please fax completed authorization to 734-232-1230 without a coversheet.**

3. Note: By signing this document, information will be disclosed by Michigan Medicine to the Organization listed below. While the potential for information disclosed could be subject to re-disclosure by the recipient and to no longer be protected by HIPAA, the Organization listed below is obligated to maintain the confidentiality of the information.

4. *Organization name: _____

*Street address: _____

*City, State & Zip: _____

*(Area code) Phone number: _____

*Required information

- This authorization does not expire unless I revoke (cancel) it.
- Revoking (cancelling) authorization:** I may revoke this authorization at any time. Revocations must be made in writing and sent to:

Michigan Medicine
 Revenue Cycle Mid Service (HIM)
 Health Information Exchange (HIE) Support Unit
 3621 S. State Street 700 KMS Place,
 Bay 11 – Mid Service
 Ann Arbor, MI 48108-1633
 Phone: (734) 615-0872 Option 2
 Fax: (734) 998-0105

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.

_____/_____/_____
***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