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 TO RELEASE COPIES OF A MEDICAL RECORD** *(Patient Requests Information To Be Sent From UMHS)*	**For Office Use Only:** **Information:** ☐ Mailed ☐ Picked Up ☐ Faxed **ID Verified:** ☐ Yes ☐ No **Date Received:** _____ **Date Processed:** _____ **Processed By:** _____ ☐ HIM Staff ☐ Other: _____

Please complete this form in its entirety so we can help you receive the information you are requesting.

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. A separate form is required for release of psychotherapy (progress) notes. Please see the second page for our fee schedule.***

Patient Name: _____ Date of Birth: _____

Street Address: _____ UM Registration #: _____

City/State/Zip: _____ Telephone #: _____

Email Address: _____ Fax #: _____

Select delivery method: ☐ **eDelivery (secure web link)** ☐ **Fax** ☐ **US Mail** ☐ **Certified Overnight Delivery (extra charge)**

2. **I am the patient, 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 patient information listed above) to:**

☐ Myself
☐ Other Person: _____ Company/Organization: _____

Street Address: _____

City/State/Zip: _____ Telephone #: _____

Email Address: _____ Fax #: _____

3. **Purpose of release/disclosure to other person/organization:**

Reason for Disclosure	Recommended Record Set (as described in Section 4)
☐ Continuation of Care/Transfer of Care	Package 1
☐ Attorney/Legal	Package 2 for a selected date range
☐ Insurance Company	Package 2 for a selected date range
☐ Workman's Compensation	Package 3 from date of incident

☐ Other (Specify): _____

4. **Record set to be released to the party indicated above:**

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*.

Package selections (as recommended in Section 3, more may be specified below):

☐ Package 1: Key Clinical Written Documentation (includes, as applicable, history & physical, discharge summary, operative reports, consults, outpatient visit notes, test reports, ER clinician notes) for the past 24 months.

☐ Package 2: All Clinical Written Documentation from _____ (Start Date) to _____ (End Date) (includes, as applicable, Package 1 contents along with nursing notes, flow sheets, medication administration records, physician orders, etc.).

☐ Package 3: Key Clinical Written Documentation (Package 1 contents) related to a specific incident, injury or illness from ____/____/_____ (mm/dd/yyyy). (Date of Incident)

Other selections:

From Dates of Service: ____/____/_____ (mm/dd/yyyy) (Start Date) to ____/____/_____ (mm/dd/yyyy). (End Date)

☐ Laboratory test result reports ☐ Reports for Radiology/Other Diagnostic Testing

☐ Images/Films (*Additional charges may apply for this service. Requests should be forwarded to the Radiology department.*)
☐ MRI ☐ CT Scan ☐ Ultrasound ☐ X-Rays ☐ Breast Imaging (Mammograms, Breast Ultrasound, Breast MRI)
☐ Gastrointestinal Radiology ☐ Genitourinary Radiology

☐ Billing Information (*For billing request status, please call (800) 992-9475.)*

☐ Other Records (*Please specify*): _____

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5. **This authorization expires on:** _____ (*specify expiration date or event*)**.**
   If the expiration date is left blank, the authorization expires 60 days 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.

_____ ____/____/_____

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**

8. **Payment: There will be fees associated with most record requests. In some cases, payment must be received before records can be released. If you would like to pay for your records in advance, please provide the necessary credit card information on the following form (page). Should your record fees exceed 50.00, you will be contacted to approve the fee before your request will be processed.**

Additional Information Regarding Your Request

REQUESTING MEDICAL RECORDS ON BEHALF OF ANOTHER PERSON

If you are requesting medical records for someone other than yourself, you may be required to provide additional documentation to show that you have a legal right to request the record set. Examples of these documents include Letters of Representation, Guardianship Papers, Affidavits of Heir at Law, etc. Please contact the Release of Information Unit at (734) 936-5490 to determine the documentation that will be required to process your request.

SUBMITTING REQUESTS & RECEIVING RECORD COPIES - Requests for medical records may be:

- Delivered to any University of Michigan Hospital or Health Center registration desk. *(Delivered requests will be forwarded to and processed by the Release of Unit at the Hubbard Road address.)*
- Mailed to Health Information Management, Release of Information Unit at 2901 Hubbard Rd., RM 2722, Ann Arbor, MI 48109-2435
- Faxed to (734) 936-8571

Records will be sent through US Mail. Records needed for medical emergencies will be faxed directly to a physician or medical facility. Our average turnaround time for processing requests is seven business days. Please include your phone number on your request, in case we need to contact you for additional information. **For questions regarding requests for medical record copies, please contact: Health Information Management – Release of Information at (734) 936-5490.**

FEES – Some records requested for legal, insurance, or personal use may require a prepayment. If your request requires pre-payment, a fee notice will be sent to you upon receipt of your request. Actual postage and Michigan State tax will be added to the fees outlined below. Records fees will be billed as follows:

Patients:
-Pages 1-20 are $1.10 per page
-Pages 21-50 are $.55 per page
-Pages 51 and up are $.23 per page

Attorneys and Insurance Companies:
-Clerical Fee of $22.13
-Pages 1-20 are $1.10 per page
-Pages 21-50 are $.55 per page
-Pages 51 and up are $.23 per page
-Microfiche copies are $2.00 per page

Please make your check payable to "HealthPort"

Print Form

70-10015	VER: B/11 HIM: 09/11	MEDICAL RECORD	University of Michigan Health System	AUTHORIZATION TO RELEASE COPIES OF A MEDICAL RECORD

Replaces: POD-0138