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 PATIENT INFORMATION** *(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.

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.

Patient Name: _____ **Date of Birth:** _____

Street Address: _____ **UM Registration #:** _____

City/State/Zip: _____ **Telephone #:** _____

Email address: _____ **Cell Phone #:** _____

(Email address will be used only for clarification or notification of status of request)

1. 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 information of the patient listed above) to:

☐ Myself. Patients may receive up to 30 pages free. For more than 30 pages, please see the fee schedule listed on page 2.

☐ Name of person/organization: _____

Street Address: _____

City/State/Zip: _____

Purpose of release/disclosure to other person/organization:

☐ Referral/Consult ☐Attorney/Legal ☐ Insurance Company ☐Billing ☐Other: (specify) _____

2. Specific information to be released for the timeframe of _____ **(Date)** **to** _____ **(Date).**

(If dates not specified, information related to the most recent visit or hospitalization will be provided.)

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; and demographic information, for the purposes and conditions designated on this form.*

☐ Inpatient package (includes history & physical, discharge summary, operative report, consults, test reports)
☐ Inpatient discharge summary (physician summary of your hospitalization)
☐ Outpatient package (includes outpatient visit notes and test reports for last 6 months, unless other date range requested)
☐ Outpatient surgery/procedure package (includes procedure/operative report, lab reports, related clinic visit notes)
☐ Emergency Room information (ER clinician notes, physician summary of tests performed)
☐ Written reports of tests performed (you must specify which tests, otherwise no information will be released):

_____

☐ Other information: examples include X-Ray, MRI, ultrasound images, films, CD's, or any other information (you must specify which information, otherwise no information will be released, additional fees may apply): _____

_____

☐ Patient accounting/billing request (you must specify dates) _____
Billing requests are sent to the Billing Office. For billing request status, please call (800) 992-9475

3. 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.

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4. **Revoking authorization:** I may revoke this authorization at any time. Revocations 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 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.
5. **Note:** Once information has been disclosed, UMHS can no longer protect it from further disclosure.

SIGNATURE:_____ **DATE:** _____

NAME *(please print)*: _____

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

Additional Information Regarding Your Request

REQUESTS FOR MEDICAL RECORDS OF *DECEASED* PATIENTS

Records of deceased patients may be released to the designated Personal Representative/Successor Personal Representative as stated in a written will or by the Probate Court as either the Executor or Administrator of the deceased person's estate; the beneficiary of the patient's life insurance policy; and the Heir at Law, (a person who is legally entitled by state law to inherit property of a deceased person when that person dies without a valid will). In addition to this form, the Heir at Law should complete the Affidavit of Heir form, which can be requested by calling the Release of Information Unit at 734-936-5490.

SUBMITTING REQUESTS & RECEIVING RECORD COPIES

Requests for medical records can be:

- Delivered to any University of Michigan Hospital or Health Center registration desk
- 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

For continuation of care, the inpatient or outpatient care package will be sent free of charge. Records requested for reasons other than continuing medical care are assessed fees as follows:

Patients:

- First 30 pages are FREE
- Pages 31-50 are $1. 09 per page
- Pages 51 – 80 are $.55 per page
- Pages 81 and up are $.23 per page

Attorneys and insurance companies are charged a $21.95 clerical fee, plus:

- Pages 1-20 are $1.09 per page
- Pages 21-50 are $.55 per page
- Pages 51 and up are $.23 per page
- Microfiche copies are $1.39 per page

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. **Please make your check payable to "HealthPort".**