



University Health Service  
 Division of Student Affairs  
 The University of Michigan  
 207 Fletcher Street Ann Arbor, MI 48109-1050

**Health Information Management Services:**  
 Phone #: (734) 936-3275  
 Fax #: (734) 936-3063

**AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION**

Name: \_\_\_\_\_ ID #: \_\_\_\_\_

Address (Local): \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone #: \_\_\_\_\_ Date of birth: \_\_\_\_\_

**I hereby authorize the release of health information:**

- To myself:
- To: Name of Person/Organization: \_\_\_\_\_  
 Street Address: \_\_\_\_\_  
 City, State, Zip: \_\_\_\_\_

**Specific information needed:** From(date) \_\_\_\_\_ To (date) \_\_\_\_\_

- Entire health record or  Entire health record with billing records
- Immunization  Lab results  Progress notes/summary  PAP report  X-ray report
- Substance or alcohol use/abuse  STD info  HIV testing, infection or illness info  Psychiatric info
- Photograph  Other (please specify): \_\_\_\_\_

**Purpose for this disclosure: (optional)**

- Personal  Insurance  Consultation  Continuing medical treatment
- Other (please specify) \_\_\_\_\_

**Revocation:** I understand that I have the right to revoke this authorization at any time by writing to the address above. This authorization shall remain valid until revoked or upon the expiration date/event specified below, whichever occurs first. After it is revoked or expired, UHS will make no further disclosures to the above persons without a new authorization. A request to revoke my authorization will not apply to the extent that UHS has taken action in reliance upon my authorization.

**Redisclosure:** Once information has been disclosed, it may no longer be protected from further disclosures by federal or state privacy laws.

**Conditioning of Eligibility:** UHS will not condition treatment, payment, enrollment or benefit eligibility on my signing this document.

\_\_\_\_\_  
**Patient Signature (or authorized person)** \_\_\_\_\_ **Date**

This authorization shall remain valid for 60 days unless you specify an additional time period. To specify an additional time period up to a *maximum of 12 months*, please check ONE of the boxes below. Note that if you specify an additional time period, this authorization will apply to your medical information generated during the additional time period.

- Other specific expiration date: \_\_\_\_\_ (mm/dd/yyyy) Initials \_\_\_\_\_
- Other expiration event (specify): \_\_\_\_\_ Initials \_\_\_\_\_

**For Health Service Use Only**

- Request:  In person  Written form  Telephone  Other \_\_\_\_\_
- Photo ID verified (document type):  U of M ID  Driver License  Other \_\_\_\_\_
- Information to be:  Mailed  Picked up/date needed: \_\_\_\_\_  Faxed  PW  Other \_\_\_\_\_
- Information released as requested above  Other information released (specify) \_\_\_\_\_

Completed by HIMS Staff: \_\_\_\_\_ Staff Initials/Date  
 Completed by Non-HIMS Staff: \_\_\_\_\_ Staff Initials/Date

**CONFIDENTIAL INFORMATION -TO BE USED ONLY FOR THE PURPOSE (S) REQUESTED.**