STUDENT LIFE
UNIVERSITY HEALTH SERVICE
UNIVERSITY OF MICHIGAN

Authorization to Release Protected Health Information

UHS Radiology

207 Fletcher Street, Ann Arbor, MI 48109-1050
Phone: (734) 764-8302; Fax: (734) 763-9363

UHS staff will place label here

Patient's Name: _____ UM ID#: _____ Medical Record #: _____

Current address: _____ City: _____ State: _____ Zip: _____

Telephone #: _____ Date of birth: _____ Date of last UHS visit: _____

Release Imaging information FROM *(check only one box):*

- ☐ University Health Service (address above)
- ☐ Other (*specify facility/individual, address, phone, fax):*

_____
_____
_____
_____
_____

Release information TO:

- ☐ Myself
- ☐ University Health Service (address above)
- ☐ Other (*specify facility/individual, address, phone, fax*):

_____
_____
_____
_____
_____

Date(s) of treatment: From (start date): _____ To (end date): _____

Images regarding treatment for the following condition(s) or injury(ies): _____

This authorization is limited to the following records and information (please identify records being requested):

☐ X-Ray Imaging ☐ Ultrasound Imaging ☐ Michigan Medicine Imaging ☐ Radiology Report

Purpose for this disclosure (optional): ☐ Personal ☐ Insurance ☐ Consultation ☐ Continuing medical treatment
☐ Other: _____

Delivery: ☐ Pick-up ☐ US Mail ☐ Other: _____

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, UHS can no longer protect it from further disclosure.

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

_____ _____ _____

Signature (Electronic signature NOT accepted) Printed Name of Signer (First Last) Date of Signature

If signed by other authorized person, **Relationship to Patient**: _____

For Health Service Use Only

Request received: ☐ In person ☐ Written form ☐ Telephone ☐ Fax ☐ Other: _____

Identity verified by: ☐ UM ID ☐ Driver license ☐ Signature ☐ Other: _____

Information to be: ☐ Mailed ☐ Picked up/date needed: _____ ☐ Faxed ☐ Other: _____

Request completed: ☐ Information released as requested above ☐ Other information released (specify): _____

Completed by (Radiology staff initials and date:) _____

Confidential information – To be used only for the purpose(s) requested