STUDENT LIFE
UNIVERSITY HEALTH SERVICE
UNIVERSITY OF MICHIGAN

Authorization for Verbal Communication of Protected Health Information

Please send requests to:
University Health Service
Health Information Management (HIM)
207 Fletcher St.
Ann Arbor, Michigan 48109-1050
Phone 734-936-3275, Fax 734-936-3063
Email UHS-ROIRequest@med.umich.edu

Patient's name: _____ U-M ID #: _____ Medical record #: _____

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

Telephone #: _____ Date of birth: _____

I permit University Health Service (UHS), their physicians, nurses, and other personnel ("Health Care Providers") to discuss my health information, in person or by telephone, with the following family members or others directly involved in my medical care (list family members/others and state the person's relationship to the patient):

	Name:	Phone number:	Relationship:
1.			
2.			
3.			
4.			

Release of information under this document is limited to verbal discussions with my Health Care Providers. **This document does not permit release of any *written* health information to the individuals named above.**

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

I request the following information to be released, which may include *alcohol and drug abuse/treatment; psychological and social work counseling; HIV or 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.*

☐ **Entire** health record *or select one or more of the options listed below:*

☐ Visit notes ☐ Immunizations ☐ Lab results ☐ HIV-related ☐ Mental health ☐ Eye care
☐ Physical therapy ☐ Radiology ☐ Substance use ☐ STI-related ☐ Women's health
☐ Other (specify): _____

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

This form does not expire unless revoked or updated.

Signature of patient (Electronic signature *not* accepted): _____ Date of signature: _____

For Health Service Use Only

Request received: ☐ In person ☐ Written form ☐ Telephone ☐ Fax ☐ Other: _____
Identity verified by: ☐ UM ID ☐ Driver license ☐ Signature ☐ Other: _____
Request completed by: HIM staff initials/date: _____ Other staff initials/date: _____