STUDENT LIFE
UNIVERSITY HEALTH SERVICE
UNIVERSITY OF MICHIGAN

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

Authorization to Release Protected Health Information

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

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

Telephone #: _____ Date of birth: _____ Last 4 digits of Social Security #: _____

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

☐ University Health Service
Health Information Management (HIM)
207 Fletcher Street, Ann Arbor, MI 48109-1050

☐ Other (*specify facility/individual, address, phone, fax)*

_____
_____
_____
_____

Release information TO:

☐ Myself

☐ University Health Service
Health Information Management (HIM)
207 Fletcher Street, Ann Arbor, MI 48109-1050

☐ Other (*specify facility/individual, address, phone, fax*)

_____
_____
_____
_____

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. A request for an entire health record does not routinely include records sent to UHS from a previous health care provider.*

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

☐ Immunizations ☐ Lab results ☐ Progress notes ☐ PAP report ☐ Radiology report ☐ Radiology images

☐ Substance or alcohol use/abuse ☐ STI info ☐ HIV-related info ☐ Psychiatric info ☐ Other (specify): _____

☐ Partial health record, which contains immunizations, two (2) years of office visit and lab information, and five (5) years of radiology and diagnostic reports. This is sufficient to meet the needs of many requests, including transferring your care to a new provider.

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

☐ Other: _____

Delivery: ☐ Pick-up ☐ US Mail ☐ MyUofMHealth.org account – for records after 6/2012 ☐ 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.

This authorization shall remain valid for 60 days unless you specify an additional time period, *up to a maximum of 12 months*. _____
Other expiration date

_____ _____ _____
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: ☐ U-M ID ☐ Driver license ☐ Signature ☐ Other: _____

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

Request completed by: HIM staff initials/date: _____ Other staff initials/date: _____

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