University of Michigan Health System
Health Information Management (HIM)
Release of Information (ROI) Unit
2901 Hubbard Rd #2722
Ann Arbor, Michigan 48109-2435
Phone: (734) 936-5490
Fax: (734) 936-8571

AUTHORIZATION TO RELEASE COPIES OF A MEDICAL RECORD

(Patient Requests Information To Be Sent From UMHS)

For Clinic Use Only:

☐ **Records sent from Clinic – please image form to patient record**
☐ Mailed ☐ Picked Up ☐ Faxed
Date Received: _____
Date Processed: _____
Processed By: _____

☐ **Forwarding Request to ROI for processing**

Please complete this form in its entirety so we can help you receive the information you are requesting.

1. ***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. Please see the second page for our fee schedule.***

Patient Name: _____ Maiden/AKA: _____ Date of Birth: _____
Street Address: _____ UMHS MRN: _____
City/State/Zip: _____ Telephone #: _____
Email Address: _____

2. ☐ **Myself:** I request the UMHS to release my protected health information to Myself to the address listed above.
Select delivery method: ☐ **eDelivery (secure web link)** ☐ **US Mail** ☐ **Certified Overnight Delivery (extra charge)**

3. ☑ **Other:** I am the patient, or the legally authorized representative of the patient listed above and request the UMHS to release my protected health information (or the patient information listed above) to:

Individual/Person: _____ Company/Organization: **C D Services, Inc.**
Street Address: **24027 Research Drive**
City/State/Zip: **Farmington Hills, MI 48335** Telephone #: **248-476-1700**
Select delivery method: ☐ **Fax #** (health providers only): _____
☑ **US Mail** ☐ **Certified Overnight Delivery (extra charge)**

*If this request is to send records to another health care provider, is this a change in your primary care doctor? If yes, please initial for the change to be applied in your medical record. _____ **(initials required)**

4. **Purpose of release/disclosure to other person/organization:**

Reason for Disclosure	Recommended Record Set (as described in Section 5)
☐ Continuation of Care/Transfer of Care	Package 1
☑ Attorney/Legal	Package 2 for a selected date range
☐ Insurance Company	Package 1 for a selected date range
☐ Workman's Compensation	Package 1 from date of incident
☑ Other (specify): **At my request**	

5. **Record set to be released to the party indicated above:**

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

Package selections (as recommended in Section 4, more may be specified below):

☐ Package 1: **Key Clinical** Written Documentation (includes, as applicable, history & physical, discharge summary, operative reports, consults, outpatient visit notes, test reports, ER clinician notes) related to a specific incident, injury or illness from ____/____/_____ (mm/dd/yyyy) to ____/____/_____ (mm/dd/yyyy). If no dates listed, for the past 24 months.

☐ Package 2: **All Clinical** Written Documentation from ____/____/_____ (mm/dd/yyyy) to ____/____/_____ (mm/dd/yyyy) (includes, as applicable, Package 1 contents along with nursing notes, flow sheets, medication administration records, physician orders, etc.).

Other selections: From Dates of Service: ____/____/_____ (mm/dd/yyyy) to ____/____/_____ (mm/dd/yyyy)

☐ Immunization Report
☐ Billing Information (*For billing request status, please call (800) 992-9475.)*
☐ Clinical Photographs from: _____ (department)
☐ Laboratory test result reports
☐ Reports for Radiology/Other Diagnostic Testing
☐ Films/Images (*Released by Radiology Department; Additional charges may apply for this service.)*
☐ MRI ☐ CT Scan ☐ Ultrasound ☐ X-Rays ☐ Breast Imaging (Mammograms, Breast Ultrasound or MRI)
☐ Pathology Slides *(Released by Pathology Department; Additional charges may apply for this service.)*
☐ Other Records (*Please specify*): _____

University of Michigan Health System Health Information Management (HIM) **Release of Information (ROI) Unit** 2901 Hubbard Rd #2722 Ann Arbor, Michigan 48109-2435 Phone: (734) 936-5490 Fax: (734) 936-8571	**AUTHORIZATION TO RELEASE COPIES OF A MEDICAL RECORD** *(Patient Requests Information To Be Sent From UMHS)*	**For Clinic Use Only:** ☐ **Records sent from Clinic – please image form to patient record** ☐ Mailed ☐ Picked Up ☐ Faxed **Date Received:** _____ **Date Processed:** _____ **Processed By:** _____ ☐ **Forwarding Request to ROI for processing**

6. **This authorization expires on:** One year from signature date (*specify expiration date or event*). **If the expiration date is left blank, the authorization expires 60 days from the signature date.**
7. **Revoking (cancelling) authorization:** I may revoke (cancel) this authorization at any time. Revocations (cancellations) 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 (cancellations) 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.
8. **Note: O**nce information has been disclosed, UMHS can no longer protect it from further disclosure.
9. **Payment: There will be fees associated with most record requests. The fees are outlined below.**

_____ ____/____/____

Signature of Patient or Legally Authorized Representative (if patient is a minor or unable to sign) **DATE** (mm/dd/yyyy)

_____

Printed Name of Legally Authorized Representative (if patient is a minor or unable to sign)

Relationship to Patient: ☐ **Spouse** ☐ **Parent** ☐ **Next-of-Kin** ☐ **Legal Guardian** ☐ **DPOA for Healthcare**

Additional Information Regarding Your Request

REQUESTING MEDICAL RECORDS ON BEHALF OF ANOTHER PERSON

If you are requesting medical records for someone other than yourself, you may be required to provide additional documentation to show that you have a legal right to request the record set. Examples of these documents include Letters of Representation, Guardianship Papers, Affidavits of Heir at Law, etc. Please contact the Release of Information Unit at (734) 936-5490 to determine the documentation that will be required to process your request.

SUBMITTING REQUESTS & RECEIVING RECORD COPIES - Requests for medical records may be:

- Mailed to Health Information Management, Release of Information Unit at 2901 Hubbard Rd., RM 2722, Ann Arbor, MI 48109-2435
- Faxed to Health Information Management, Release of Information Unit at (734) 936-8571
- Submitted in person Monday-Friday 8:00 AM – 5:00 PM to the Release of Information Unit at Hubbard Road location noted above.

Unless otherwise noted/requested, 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 Unit at (734) 936-5490.**

FEES are authorized annually by the State of Michigan Medical Records Access Act, P.A. 47 of 2004, MCL 333.26269. 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 to the fees outlined below. Records fees will be billed as follows:

Patients:
-Pages 1-20 are $1.17 per page
-Pages 21-50 are $0.59 per page
-Pages 51 and up are $0.23 per page

Attorneys and Insurance Companies:
-Clerical Fee of $23.42
-Pages 1-20 are $1.17 per page
-Pages 21-50 are $0.59 per page
-Pages 51 and up are $0.23 per page + Actual postage
-Microfiche copies are $1.50 per page