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 send form to Central Imaging**
☐ 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 Michigan Medicine 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:_____ MRN (optional):_____

City/State/Zip:_____ Telephone #:_____

Email Address:_____

2. ☐ **Myself:** I request Michigan Medicine to release my protected health information to Myself to the address listed above.
Select delivery method: ☐ **MyUofMHealth.org** Patient Portal ☐ **Electronic (email web link)** ☐ **US Mail**

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

Individual/Person:_____ Company/Organization: **RECORDS DEPOSITION SERVICE**

Street Address: **PO BOX 5054**

City/State/Zip: **SOUTHFIELD, MI 48086-5054** Telephone # **248-357-3330**

Select delivery method: ☐ **Fax #**(only health providers / urgent): _____
☐ **US Mail** ☐ **Certified Overnight Delivery (extra charge)** ☒ **E-mail** **RDSMICHIGAN@GMAIL.COM**

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
☐ Patient Directive	As directed by Patient
☐ Other (specify):	

5. Record set to be released to the party indicated above: Use form 70-10232 for release of alcohol / substance use disorder info.
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 all nursing notes, flow sheets, medication administration records, physician orders, etc.).

☐ Other Records (*Please specify*): _____

_____

☐ Only Specific Providers:_____

Please contact the individual departments below to request their records (as applicable):
*Billing Records – Call (855) 855-0863
*Radiology Films Images: Call (734) 936-4517 Additional Charges May Apply
*Pathology Slides: Call (800) 862-7284 Additional Charges May Apply

70-10015	VER: A/20 HIM: 08/21	MEDICAL RECORD	MICHIGAN MEDICINE UNIVERSITY OF MICHIGAN	HIM ROI AUTHORIZATION

Replaces: POD-0138

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6. **This authorization expires on:** _____ (*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 Michigan Medicine Revenue Cycle Mid Service (HIM) 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:** Once information has been disclosed, Michigan Medicine can no longer protect it from further disclosure.

9. **Payment: There will be fees associated with most record requests as outlined below.** ☒ Check if Fee Approval Required

_____ _____/_____/_____
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 (attach copy)**

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 Revenue Cycle Mid Service (HIM), Release of Information Unit at 3621 S. State Street 700 KMS Place, Bay 11 - Mid Service Ann Arbor, MI 48108-1633
- Faxed to Revenue Cycle Mid Service (HIM), Release of Information Unit at (734) 936-8571

Our average turnaround time for processing requests is five business days plus shipping time. Unless otherwise requested, records will be sent through US Mail. Records needed for medical emergencies will be faxed directly to a physician or medical facility. 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: Revenue Cycle Mid Service (HIM) – Release of Information Unit at (734) 936-5490.**

FEES are authorized and updated annually by the State of Michigan Medical Records Access Act, P.A. 47 of 2004, MCL 333.26269. **Additional fee guidance is provided under federal regulations.** 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. The current Fee Schedule can be found at https://www.uofmhealth.org/patient-visitor-guide/medical-records. Records fees will be billed as follows as of April 2018:

Patients:
-MyUofMHealth Patient Portal – No fee
-Electronic Records Electronic Delivery – See Fee Schedule
-Electronic records to Paper Mailed – See Fee Schedule
- Paper Records Electronic Delivery – See Fee Schedule
- Paper Records to Paper Mailed – See Fee Schedule

Attorneys, Insurance Companies and Third Parties:
-Intial Fee as permitted by State Law – See Fee Schedule
-Per Page Fees – See Fee Schedule
-Actual Postage Fees as Applicable
-Patient Directives – See Fee Schedule