University of Michigan Health System Health Information Management **Release of Information Unit** 2901 Hubbard Rd #2722 Ann Arbor, Michigan 48109-2435 Phone: (734) 936-5490 Fax: (734) 936-8571	**Authorization For Clinical Communication**	MRN: NAME: BIRTHDATE: CSN:

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.

Patient Name:______________________________ Maiden/AKA:__________________________ Date of Birth:_________________
Street Address:____ UMHS MRN:_________________________
City/State/Zip:____ Telephone #:__________________________
Email Address:____

2. I am the patient, or the legally authorized representative of the patient, listed above. I hereby authorize clinical communication: From UMHS (Doctor/Clinic/Unit): ____

To communicate clinical information with the following individual(s)/person(s)/ company(ies)/organization(s):

3. Specific Information Needed: From Dates: ____/____/__________ (mm/dd/yyyy) **to** ____/____/__________ (mm/dd/yyyy).

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.

- ☐ Pertinent Medical Information (Discharge Planning, Educational Evaluation, Consults, School program Planning)
- ☐ Progress Reports
- ☐ Social Work Reports
- ☐ Individual Educational Planning Committee (IEPC) Reports
- ☐ Speech / Language Evaluations
- ☐ Verbal feedback to and from home-school district personnel
- ☐ Other (specify): ____
- ☐ Report Cards
- ☐ Relevant Medical History
- ☐ Psychological/Neuropsychological Evaluations
- ☐ Test Reports

4. Purpose of Release / Disclosure:

- ☐ At the request of the patient (or patient's legally authorized representative); or
- ☐ At the request of someone other than the patient for the following purpose(s):
  - ☐ Attorney / Legal Insurance Company
  - ☐ Insurance Company
  - ☐ School Requirement
  - ☐ Social Security / Disability Certification
  - ☐ Worker's Compensation
  - ☐ Vocational Rehabilitation
  - ☐ Research (specify institution and IRB#): ____
  - ☐ Other (specify): ____

5. This authorization expires on: ____ **(specify expiration date or event). If the expiration date is left blank, the authorization expires 6 months from the signature date.**

6. 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.

7. Note: Once information has been disclosed, UMHS can no longer protect it from further disclosure.

____ ____/____/__________
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** ☐ **Other (specify):**____________________