

For Office Use Only	
Information:	<input type="checkbox"/> Mailed <input type="checkbox"/> Picked Up <input type="checkbox"/> Faxed
ID Verified:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Supporting Info Received:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Request Processed By:	<input type="checkbox"/> HIM Staff <input type="checkbox"/> Other

Authorization to Release Patient Information

This authorization is voluntary. I understand that my medical treatment provider will not condition treatment, payment, enrollment, or eligibility for benefits on my signing this document.

Patient Name	Date of Birth										
Address	City State ZIP + 4 digits										
Telephone	Social Security Number (last four digits)										
Patient/Reg. No. (if known)	Date of Injury/Illness (if known)										
Medical Treatment Provider(s)											
<p>1. I am the patient listed above or the legally authorized representative of the patient listed above. I request that all medical treatment providers release my protected health information (or the information of the patient listed above) to:</p> <p style="text-align: center;">University of Michigan WorkConnections Argus II Building 400 South Fourth Street Ann Arbor, MI 48103-4816</p>											
<p>2. Purpose of Release/Disclosure: <input type="checkbox"/> Insurance Claim <input type="checkbox"/> Disability Certification <input type="checkbox"/> Workers' Compensation</p>											
<p>3. I authorize the release of all medical treatment information unless otherwise excluded. This authorization excludes release of medical information for the following conditions:</p> <table style="width: 100%;"> <tr> <td><input type="checkbox"/> Alcohol and drug abuse/treatment</td> <td><input type="checkbox"/> Demographic information</td> </tr> <tr> <td><input type="checkbox"/> Hepatitis</td> <td><input type="checkbox"/> HIV or AIDS or ARC communicable disease or infections</td> </tr> <tr> <td><input type="checkbox"/> Psychological and social work counseling</td> <td><input type="checkbox"/> Sexually transmitted diseases</td> </tr> <tr> <td><input type="checkbox"/> Venereal disease</td> <td><input type="checkbox"/> Tuberculosis</td> </tr> <tr> <td colspan="2"><input type="checkbox"/> Other (Specify) _____</td> </tr> </table>		<input type="checkbox"/> Alcohol and drug abuse/treatment	<input type="checkbox"/> Demographic information	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> HIV or AIDS or ARC communicable disease or infections	<input type="checkbox"/> Psychological and social work counseling	<input type="checkbox"/> Sexually transmitted diseases	<input type="checkbox"/> Venereal disease	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Other (Specify) _____	
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<p>This authorization is in effect for 12 months from the date of execution.</p> <p>Revoking authorization: I may revoke this authorization at any time. Revocations must be made in writing and sent to WorkConnections. Revocations 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.</p> <p>Redisclosure: Once information has been disclosed under this authorization, it may no longer be protected from further disclosures by federal or state privacy laws.</p>											
SIGNATURE _____ DATE _____											
NAME (print) _____											
Relationship to Patient: <input type="checkbox"/> Parent <input type="checkbox"/> Legal Guardian <input type="checkbox"/> Other (proof of legal authority may be required)											