WORK CONNECTIONS
UNIVERSITY OF MICHIGAN

Illness and Injury Assistance

Argus II Building
400 South Fourth Street
Ann Arbor, MI 48103-4816

Phone: (734) 615-0643
Toll-free: (877) 869-5266
Fax: (734) 936-1913
E-mail: Work.Connections@umich.edu
Website: workconnections.umich.edu

For Office Use Only
Information: ☐ Mailed ☐ Picked Up ☐ Faxed
ID Verified: ☐ Yes ☐ No
Supporting Info Received: ☐ Yes ☐ No
Request Processed By: ☐ HIM Staff ☐ 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)			

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:

University of Michigan
Work Connections
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400 South Fourth Street
Ann Arbor, MI 48103-4816

2. Purpose of Release/Disclosure: ☐ Insurance Claim ☐ Disability Certification ☐ Workers' Compensation

3. I authorize the release of all medical treatment information unless otherwise excluded. This authorization excludes release of medical information for the following conditions:

☐ Alcohol and drug abuse/treatment
☐ Hepatitis
☐ Psychological and social work counseling
☐ Venereal disease
☐ Other (Specify) _____
☐ Demographic information
☐ HIV or AIDS or ARC communicable disease or infections
☐ Sexually transmitted diseases
☐ Tuberculosis

This authorization is in effect for 12 months from the date of execution.

Revoking authorization: I may revoke this authorization at any time. Revocations must be made in writing and sent to Work Connections. 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.

Redisclosure: Once information has been disclosed under this authorization, it may no longer be protected from further disclosures by federal or state privacy laws.

SIGNATURE _____ DATE _____

NAME (print) _____
Relationship to Patient: ☐ Parent ☐ Legal Guardian ☐ Other (proof of legal authority may be required)