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E-mail: Work.Connections@umich.edu Website: workconnections.umich.edu

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	
Phone	Social Security number (last four digits)		Date of in	Date of injury/illness (if known)	
If treatment is within the	University of Michigan Hea	alth System, you have the optic	on of listing: <i>Michigan M</i>	edicine	
Name of medical treatm	ent provider(s):				
Phone number(s):					
Fax number(s):					
medical treatment pro		ized representative of the pati ed health information (or the i			
2. Purpose of release/di	sclosure: 🗆 Medical leav	ve/FMLA □ Workers' Com	pensation		
☐ Alcohol and drug a☐ Hepatitis		e following checked conditions Demographic informa HIV or AIDS or ARC o Sexually transmitted Tuberculosis	ation communicable disease o	rinfections	
This authorization is in	effect for 12 months from the	e date of execution.			
Revoking authorization: Work Connections. Revo as a condition of providi	I may revoke this authoriza ocations will not apply to info	ation at any time. Revocations formation that already has bee authorization will not apply to number the policy, or the policy.	en released. If this author o my insurance company	ization was obtained	
Redisclosure: Once info disclosures by federal o		d under this authorization, it m	ay no longer be protecte	d from further	
Signature				Date	
NI / : ()					
	atient: 🗆 Parent 🗆 Legal gu		uthority may be required)		