WORK CONNECTIONS
UNIVERSITY OF MICHIGAN
Illness and Injury Assistance

1000 Victors Way
Work Connections
Ann Arbor, MI 48108

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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 (mm/dd/yy

Address | City | State | ZIP

Phone | Date of injury/illness (if known)

If treatment is within the University of Michigan Health System, you have the option of listing: *Michigan Medicine*

Name of medical treatment provider(s):_____

Phone number(s):_____

Fax number(s):_____

1. I am the patient listed above or the legally authorized representative of the patient listed above. I request that all medical treatment provider(s) release my protected health information (or the information of the patient listed above) to *University of Michigan Work Connections*

2. Purpose of release/disclosure: ☑ Medical leave/FMLA ☐ Workers' Compensation

3. **Please do not release** medical information for the following checked conditions:

- ☐ Alcohol and drug abuse/treatment
- ☐ Hepatitis
- ☐ Psychological and social work counseling
- ☐ Venereal disease
- ☐ 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)