UNIVERSITY OF MICHIGAN MARY A. RACKHAM INSITUTE INCLUDES:
- University Center for the Child and Family
- University Center for Language and Literacy
- University Psychological Clinic
Phone (734)615-7853 Fax (734)764-8128

AUTHORIZATION TO RELEASE AND/OR RECEIVE PATIENT INFORMATION

EXPECT TO RECEIVE RECORDS IN 2-4 WEEKS

I AUTHORIZE THE UNIVERSITY OF MICHIGAN MARY A. RACKHAM INSTITUTE (MARI) ITS AGENTS AND ITS EMPLOYEES TO RELEASE PROTECTED HEALTH INFORMATION ABOUT ME / MY CHILD TO/FROM THE RECIPIENT WHICH MAY INCLUDE ALCOHOL AND DRUG ABUSE TREATMENT; PSYCHOLOGICAL AND SOCIAL WORK COUNSELING; HIV OR AIDS OR ARC; COMMUNICABLE DISEASE OR INFECTIONS, INCLUDING SEXUALLY TRANSMITTED DISEASES, VENEREAL DISEASE, TUBERCULOSIS AND HEPATITIS; AND DEMOGRAPHIC INFORMATION; FOR THE PURPOSES, AND UNDER THE CONDITIONS DESIGNATED ON THIS FORM.

PATIENT:

Patient's Name ______________________

Patient's Address ______________________

City, State, Zip Code ______________________

Patient's Date of Birth ______________ Phone Number ______________

RECIPIENT:

Self or Name of Physician, Institution, Clinic, or Family Members Etc. ______________________

Address ______________________

City, State, Zip Code ______________________

Phone Number ______________ FAX Number ______________

INFORMATION TO BE DISCLOSED:

Dates of Service: From ______________ to ______________

- ☐ Diagnostic/Consultation Evaluation
- ☐ Outpatient Reports
- ☐ Inpatient Reports
- ☐ Speech Progress Notes & Reports
- ☐ Laboratory
- ☐ Psychological Test Reports
- ☐ Treatment Summary
- ☐ Progress Notes
- ☐ Laboratory
- ☐ Psychological Test Reports
- ☐ Other (specify) ______________________
- ☐ **All of the above information**
- ☐ Billing information From______________ to ______________

PURPOSE (S) FOR WHICH THE INFORMATION MAY BE DISCLOSED:

- ☐ At the Request of the Patient
- ☐ Continuation of Care/Consultation
- ☐ Social Security/Disability Certification
- ☐ Insurance Claim/Application
- ☐ Attorney Inquiry/Legal Matter
- ☐ Worker's Compensation
- ☐ Conversation only, no records to be sent
- ☐ Other: (specify) ______________________

Format: _______ Paper _______ Electronic (pdf)

TO OBTAIN PATIENT INFORMATION FROM ANOTHER HEALTH ORGANIZATION:

☐ **I authorize release of information from:**

Name of Physician, Institution, Clinic, etc. ______________________

Address ______________________

City, State, Zip Code ______________________

Please send information requested to:

- ☐ Mary A. Rackham Institute or specify a specific center:
  - ☐ University Center for Language & Literacy
  - ☐ University Center for the Child and Family
  - ☐ Univeristy Psychological Clinic

500 East Washington Street, Suite 100, Ann Arbor, MI 48104-2059

EXPIRATION (may be a specific date or a condition; if left blank, expires 12 months from signed date below):

This authorization expires ______________________________________

REVOCATION, REDISCLOSURE, AND CONDITIONING OF ELIGIBILITY:

REVOCATION: I understand that I may revoke my authorization by writing to the Mary A. Rackham Institute (MARI), 500 East Washington Street, Suite 100, Ann Arbor, MI 48104-2059; (734) 615-7853; Fax (734) 764-8128. After it is revoked, MARI will make no further disclosures to the above persons without a new authorization. MARI can rely on this authorization until it is revoked, or until the expiration date or conditions are met. A request to revoke my authorization will not apply to the extent MARI has taken action in reliance upon my authorization. In the event that the authorization was obtained as a condition of providing insurance coverage, the revocation will not apply to my insurance company to the extent that 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, it may no longer be protected from further disclosures by federal or state privacy laws. **CONDITIONING OF ELIGIBILITY:** UCLL will not condition treatment, payment, enrollment, or benefit eligibility on my signing this document.

AUTHORIZATION SIGNATURE

SIGNATURE:______________________________ **DATE:**______________________________

(Patient, Parent, Legal Representative)

AUTHORIZATIONS SIGNED BY A LEGAL REPRESENTATIVE MUST INCLUDE A COPY OF THE GUARDIANSHIP PAPERS OR A POWER OF ATTORNEY