

**REQUEST FOR THE USE AND DISCLOSURE OF  
PROTECTED HEALTH INFORMATION**

MRN: \_\_\_\_\_

Patient Name (print) _____	Address _____
Date of Birth _____	Daytime Telephone Number _____
XXX-XX-_____ Last 4-digits of SS#	

**INFORMATION TO BE RELEASED/RECEIVED FROM:**

Check the UMMS Affiliate:  UMMC  UMMC Midtown  UM SJMC  UM SJMG  UM BWMC  UM CMG  UM CRMC  UM HMH  
 UM Rehab & Ortho Institute  UM Shore Easton  UM Shore Dorchester  UM Shore Chestertown  UM UCMC

Other Provider Name/Organization: \_\_\_\_\_

Address: \_\_\_\_\_

Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_

**SEND INFORMATION TO:**  Myself at the address above unless noted below.  Affiliate name above \_\_\_\_\_

Provider Name/Organization: Records Deposition Service

Address: P.O. Box 5054, Southfield, MI 48086-5054

Phone #: (248) 357-3330 Fax #: (248) 357-3337

**FORMAT OF INFORMATION TO BE DISCLOSED:**

Paper  Electronic (CD/Thumb drive)  Email (pdf format) Address: requests@recdep.com

MyPortfolio (pdf format) By signing below you acknowledge that the security of transmission is not guaranteed.

**INFORMATION TO BE DISCLOSED:**

SERVICE TYPE	DATE FROM	DATE TO	SPECIFIC INFORMATION	SPECIAL REQUEST
<input type="checkbox"/> Inpatient	_____	_____	_____	<input type="checkbox"/> Radiology Images
<input type="checkbox"/> Outpatient	_____	_____	_____	<input type="checkbox"/> Itemized Bill
<input type="checkbox"/> Emergency	_____	_____	_____	
<input type="checkbox"/> Other	_____	_____	_____	

**I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.** Only such records and/or information believed necessary for the purpose expressed above shall be released.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this request, I must do so in writing and present my written revocation to the Health Information Management Department. I understand that the revocation will not apply to information that has already been released in response to this request. This request will expire on \_\_\_\_\_. If I fail to specify an expiration date or event, this authorization will expire one year from the date it was signed and is only valid for information preceding this date. I understand that I may receive a copy of this form after I sign it and inspect and copy information to be used or disclosed. **I also understand there may be a charge for this information.**

I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. I understand authorizing the use or disclosure of the information identified above is voluntary. I do not need to sign this form to ensure treatment.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Patient or Representative

\_\_\_\_\_  
Relationship to Patient\*

\*If not signed by patient or parent of a minor, authorizing documentation is required.