Authorization to Release Patient Information

SCHOOL OF DENTISTRY
UNIVERSITY OF MICHIGAN

Central Records
University of Michigan School of Dentistry
1011 N. University Ave.
Ann Arbor, MI. 48109-1078
Phone: 734-764-6152 Fax: 734-615-7040
Email: dentalrecordcopy@umich.edu

I AUTHORIZE THE UNIVERSITY OF MICHIGAN SCHOOL OF DENTISTRY, ITS AGENTS AND ITS EMPLOYEES TO RELEASE PROTECTED HEALTH INFORMATION ABOUT ME / MY CHILD TO 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 INFORMATION

First Name	Last Name		Date of Birth
Street Address	City, State	Zip Code	Phone Number
Email:			

SEND RECORDS TO: (Choose only ONE Delivery Option)

☐ **SEND BY MAIL TO:**

Self or Name of Dentist, Physician, Institution, Clinic, Etc.
Legal-Ease Digital Imaging, LLC

Address
2496 Meadowcroft Dr

City, State, Zip Code
Burton, MI 48519

Phone Number 1-855-543-4003

☑ **SEND BY ENCRYPTED EMAIL TO:**

Self or Name of Provider/Clinic	Phone Number
Legal-Ease Digital Imaging, LLC	1-855-534-4003

E-mail pat.legalease@gmail.com

INFORMATION TO BE DISCLOSED:

☐ Recent xrays/ treatment notes
(May take two business days to complete)

☐ Specific Information_____
(Archived records may take two weeks to complete)

PURPOSE(S) FOR DISCLOSING INFORMATION:

☐ Consultation
☑ Attorney Inquiry/Legal Matter
☐ Insurance Claim
☐ **Other:** _____

EXPIRATION (may be a specific date or a condition; if left blank, expires 6 months from date below):

This authorization expires: _____

REVOCATION, REDISCLOSURE, AND CONDITIONING OF ELIGIBILITY:

REVOCATION: I understand that I may revoke my authorization by writing to the School of Dentistry, Attention: Central Records, 1011 N. University, Ann Arbor, MI 48109-1078. After it is revoked, UM School of Dentistry will make no further disclosures to the above persons without a new authorization. UM 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 UM 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: UM will not condition treatment, payment, enrollment, or benefit eligibility on my signing this document.

SIGNATURE:_____ AUTHENTIC SIGNATURE ONLY **DATE:** _____

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