Michigan Medicine **Family and Friends Outpatient**	MRN: NAME: BIRTHDATE:

This form does not give the people listed below the right to access medical information or medical records. * To give a Michigan Medicine employee authorization to electronically access the patient's electronic medical record, please fill out the form titled "AUTHORIZATION TO VIEW ELECTRONIC PATIENT INFORMATION". **

This form documents my request to allow family members and/or friends to be involved in **verbal** discussions regarding my health care. The people listed below may receive any **verbal** information needed to participate in my care or to help me make decisions. By signing this form, I permit staff within outpatient clinics*** at Michigan Medicine to discuss information about me with the people listed below. This information may include diagnoses, test results, treatment options and other information from previous outpatient or inpatient services.

- I understand that signing this form is voluntary and that information may be released to family members or others without this form, if allowed by federal and state law. ****
- I understand that listing people on this form does not give them the right to receive or copy my medical records.
- It does not allow them to consent for health care services on my behalf.
- I understand this form is NOT to be used to request a restriction of my information.

☐ I grant permission to those persons listed below to receive verbal communication regarding billing related to my care.

NAME	PHONE	RELATIONSHIP

The following information has special protection under Michigan law and **will not be disclosed** without the **patient's (or, in the case of a minor patient (under age 18), the parent's/personal representative's)** explicit permission. This information will be made available to the people I've listed above **only if I indicate my approval by initialing the line(s) below:**

_____ HIV/AIDS or other communicable diseases including sexually transmitted diseases, venereal disease, tuberculosis, and hepatitis

_____ Birth control / birth control devices / pregnancy / prenatal services / abortion

_____ Mental health services

Substance Use Disorder information will not be disclosed by signing this form. Federal law requires a separate written authorization.

I can update this form at any time by completing a new form and either giving it to my clinical staff or forwarding it to: Michigan Medicine, Revenue Cycle Mid Service (HIM) – Release of Information, 3621 S. State Street 700 KMS Place, Bay 11 - Mid Service, Ann Arbor MI 48108-1633 (Fax 734-936-8571). I can revoke or cancel this form at any time by sending written notification to the same address (or fax). This form does not expire unless revoked or updated.

_____ ____/____/_____

Signature of Patient or Legally Authorized Representative (if patient is unable to sign) Date (mm/dd/yyyy)

_____

Printed Name of Legally Authorized Representative (proof of power of attorney or legal guardianship required)

Relationship: ☐ Spouse ☐ Parent ☐ Next-of-Kin ☐ Legal Guardian ☐ DPOA for Healthcare ☐ Other (specify): _____

* For AUTHORIZATION TO RELEASE COPIES OF A MEDICAL RECORD and other required forms, go to: https://www.uofmhealth.org/patient-visitor-guide/medical-records or call (734) 936-5490.

** For Authorization to View Electronic Patient Information go to: Authorization to view Electronic Patient

*** For Admissions, Emergency Department Visits and Observation Unit Stays use 70-10011 Family and Friends Inpatient - Current Admission, Emergency Department Visit and Observation Unit Stay.

**** Refer to our Notice of Privacy Practices at: https://www.uofmhealth.org/patient-visitor-guide/protecting-your-privacy-hipaa