MICHIGAN MEDICINE **Cancer Genetics** **Personal and Family History Questionnaire**	MRN: NAME: BIRTHDATE: CSN:

What is the purpose of this questionnaire? This questionnaire will gather information about the history of cancer in your family. This information will be used by the Michigan Medicine Cancer Genetics Clinic to help determine your risk of developing cancer and to decide if the cancers of your family may be related to an inherited gene variant. This information will not be used to contact your family members. Family members' initials are used to maintain their confidentiality and to reduce errors as we build your family tree. You may refuse to answer any (or all) of the questions at this time or any other time. When you return the questionnaire, you are agreeing that your family history information will be entered into a confidential computerized database and into your medical record.

What do I need to find out? Specifically, you need to try to find out the following information about your relatives with cancer:

- Type of cancer (e.g., breast, colon, ovarian, etc.)
- Unilateral or bilateral (e.g., one breast or both breasts)
- Second cancers – for relatives who developed a second cancer, did the second cancer result from spreading of the first cancer or was it considered a separate/new cancer?
- Environmental exposures (e.g., smoking, radiation, asbestos)
- Age at diagnosis
- Current age, or age and cause of death

How do I complete the questionnaire?

- Information should be provided on biological relatives (i.e., blood relatives) only. Please fill out ALL relatives, regardless of whether they have a history of cancer. For the purpose of assessing genetic risk, do not provide information about adopted, foster, or step-relatives.
- If exact age is not known, approximate (e.g., early 40s, late 60s).
- If requested information is not known, write "unknown".
- If additional space is needed, please attach another sheet of paper and indicate which question is being addressed.

How can I contact the clinic and where do I send the completed questionnaire?

See the Cancer Genetics Clinic contact information below:

Phone: 734-647-8902 Fax: 734-763-7672

Mailing Address:
ATTN: Genetics Intake Coordinator
Michigan Medicine
NCAC Cancer Call Center
2901 Hubbard Road, Room 1621
Ann Arbor, MI 48109

Website: www.uofmhealth.org/medical-services/cancer/cancer-genetics

MICHIGAN MEDICINE **Cancer Genetics** **Personal and Family History Questionnaire**	MRN: NAME: BIRTHDATE: CSN:

Name: _____ Date of birth: _____ Date of appointment: _____

Pronouns: ☐ *She/Her* ☐ *He/Him* ☐ *They/Them* ☐ *Other:* ____ Occupation: _____

Referring provider: _____ Primary care provider: _____

Phone: _____ Fax: _____ Phone: _____ Fax: _____

Is this your primary care provider? ☐ *Yes* ☐ *No*

If NO, please provide this information in the second column.

What are the main questions or concerns you would like to talk about during your appointment in the Cancer Genetics Clinic?

Are you adopted? ☐ *Yes* ☐ *No*

If YES: Do you know family/medical history about any of your biological relatives? ☐ *Yes* ☐ *No*

If YES: please complete the family history form with this information.

If NO: please skip to page 9

MICHIGAN MEDICINE **Cancer Genetics** **Personal and Family History Questionnaire**	MRN: NAME: BIRTHDATE: CSN:

Genetic Testing in your Family

Have any of your relatives had genetic testing? ☐ *Yes* ☐ *No* ☐ *Unsure*

Have any of your relatives been seen in the University of Michigan Cancer Genetics Clinic? ☐ *Yes* ☐ *No* ☐ *Unsure*

Initials	**Relationship to You**	**Sex assigned at birth** Female, Male, Intersex *Note if this differs from gender identity*	**Condition Tested**	**Laboratory**	**Result**
		☐ F ☐ M ☐ I _____			
		☐ F ☐ M ☐ I _____			
		☐ F ☐ M ☐ I _____			
		☐ F ☐ M ☐ I _____			
		☐ F ☐ M ☐ I _____			
		☐ F ☐ M ☐ I _____			
		☐ F ☐ M ☐ I _____			
		☐ F ☐ M ☐ I _____			
		☐ F ☐ M ☐ I _____			
		☐ F ☐ M ☐ I _____			
		☐ F ☐ M ☐ I _____			

Your Biological Children

If you do not have biological children, please check here ☐

Initials	**Sex assigned at birth** Female, Male, Intersex *Note if this differs from gender identity*	**Living or Deceased**	**Current Age or Age at Death**	**Cancer Diagnosis and Age at Diagnosis**	**Other Medical Conditions (please include colon polyps, precancerous skin moles, breast biopsies)**	**Number of Children and Ages**
	☐F ☐M ☐I ____________	☐L ☐D				#: ____________ Ages: ____________
	☐F ☐M ☐I ____________	☐L ☐D				#: ____________ Ages: ____________
	☐F ☐M ☐I ____________	☐L ☐D				#: ____________ Ages: ____________
	☐F ☐M ☐I ____________	☐L ☐D				#: ____________ Ages: ____________
	☐F ☐M ☐I ____________	☐L ☐D				#: ____________ Ages: ____________
	☐F ☐M ☐I ____________	☐L ☐D				#: ____________ Ages: ____________
	☐F ☐M ☐I ____________	☐L ☐D				#: ____________ Ages: ____________
	☐F ☐M ☐I ____________	☐L ☐D				#: ____________ Ages: ____________
	☐F ☐M ☐I ____________	☐L ☐D				#: ____________ Ages: ____________
	☐F ☐M ☐I ____________	☐L ☐D				#: ____________ Ages: ____________
	☐F ☐M ☐I ____________	☐L ☐D				#: ____________ Ages: ____________
	☐F ☐M ☐I ____________	☐L ☐D				#: ____________ Ages: ____________

Your Biological Siblings

If you do not have biological siblings (i.e., full-siblings, half-siblings, etc.), please check here ☐

Initials	**Full or Half-Sibling** If half-sibling, through mother (Maternal) or father (Paternal)	**Sex assigned at birth** Female, Male, Intersex *Note if this differs from gender identity*	**Living or Deceased**	**Current Age or Age at Death**	**Cancer Diagnosis and Age at Diagnosis**	**Other Medical Conditions (please include colon polyps, precancerous skin moles, breast biopsies)**	**Number of Children and Ages**
	☐ Full ☐ M ☐ P	☐ F ☐ M ☐ I ____________	☐ L ☐ D				#: __________ Ages: _________
	☐ Full ☐ M ☐ P	☐ F ☐ M ☐ I ____________	☐ L ☐ D				#: __________ Ages: _________
	☐ Full ☐ M ☐ P	☐ F ☐ M ☐ I ____________	☐ L ☐ D				#: __________ Ages: _________
	☐ Full ☐ M ☐ P	☐ F ☐ M ☐ I ____________	☐ L ☐ D				#: __________ Ages: _________
	☐ Full ☐ M ☐ P	☐ F ☐ M ☐ I ____________	☐ L ☐ D				#: __________ Ages: _________
	☐ Full ☐ M ☐ P	☐ F ☐ M ☐ I ____________	☐ L ☐ D				#: __________ Ages: _________
	☐ Full ☐ M ☐ P	☐ F ☐ M ☐ I ____________	☐ L ☐ D				#: __________ Ages: _________
	☐ Full ☐ M ☐ P	☐ F ☐ M ☐ I ____________	☐ L ☐ D				#: __________ Ages: _________
	☐ Full ☐ M ☐ P	☐ F ☐ M ☐ I ____________	☐ L ☐ D				#: __________ Ages: _________
	☐ Full ☐ M ☐ P	☐ F ☐ M ☐ I ____________	☐ L ☐ D				#: __________ Ages: _________
	☐ Full ☐ M ☐ P	☐ F ☐ M ☐ I ____________	☐ L ☐ D				#: __________ Ages: _________

MICHIGAN MEDICINE **Cancer Genetics** **Personal and Family History Questionnaire**	MRN: NAME: BIRTHDATE: CSN:

Your Biological Mother's Family

Your biological mother's family's countries of origin (i.e., China, Ireland, Nigeria): ______________________ ☐ *Unsure*

Do you have Ashkenazi Jewish ancestry? ☐ *Yes* ☐ *No* ☐ *Unsure* Have related family members (for example, first cousins) had children together? ☐ *Yes* ☐ *No* ☐ *Unsure*

	Initials	**Sex assigned at birth** Female, Male, Intersex *Note if this differs from gender identity*	**Living or Deceased**	**Current Age or Age at Death**	**Cancer Diagnosis and Age at Diagnosis**	**Other Medical Conditions (please include colon polyps, precancerous skin moles, breast biopsies)**	**Number of Children and Ages**
Your Mother		☐F ☐M ☐I __________	☐L ☐D				#: ______ Ages: ______
Your Grandmother (Mother's Mother)		☐F ☐M ☐I __________	☐L ☐D				#: ______ Ages: ______
Your Grandfather (Mother's Father)		☐F ☐M ☐I __________	☐L ☐D				#: ______ Ages: ______
Your Mother's Siblings		☐F ☐M ☐I __________	☐L ☐D				#: ______ Ages: ______
If your biological mother does not have siblings, please check here: ☐		☐F ☐M ☐I __________	☐L ☐D				#: ______ Ages: ______
		☐F ☐M ☐I __________	☐L ☐D				#: ______ Ages: ______
		☐F ☐M ☐I __________	☐L ☐D				#: ______ Ages: ______
		☐F ☐M ☐I __________	☐L ☐D				#: ______ Ages: ______
		☐F ☐M ☐I __________	☐L ☐D				#: ______ Ages: ______
		☐F ☐M ☐I __________	☐L ☐D				#: ______ Ages: ______
		☐F ☐M ☐I __________	☐L ☐D				#: ______ Ages: ______
		☐F ☐M ☐I __________	☐L ☐D				#: ______ Ages: ______

MICHIGAN MEDICINE **Cancer Genetics** **Personal and Family History Questionnaire**	MRN: NAME: BIRTHDATE: CSN:

Your Biological Father's Family

Your biological father's family's countries of origin (i.e., China, Ireland, Nigeria): ______________________________ ☐ *Unsure*

Do you have Ashkenazi Jewish ancestry? ☐ *Yes* ☐ *No* ☐ *Unsure*   Have related family members (for example, first cousins) married each other? ☐ *Yes* ☐ *No* ☐ *Unsure*

	Initials	**Sex assigned at birth** Female, Male, Intersex *Note if this differs from gender identity*	**Living or Deceased**	**Current Age or Age at Death**	**Cancer Diagnosis and Age at Diagnosis**	**Other Medical Conditions (please include colon polyps, precancerous skin moles, breast biopsies)**	**Number of Children and Ages**
Your Father		☐ F ☐ M ☐ I __________	☐ L ☐ D				#: ________ Ages: ________
Your Grandmother (Father's Mother)		☐ F ☐ M ☐ I __________	☐ L ☐ D				#: ________ Ages: ________
Your Grandfather (Father's Father)		☐ F ☐ M ☐ I __________	☐ L ☐ D				#: ________ Ages: ________
Your Father's Siblings		☐ F ☐ M ☐ I __________	☐ L ☐ D				#: ________ Ages: ________
		☐ F ☐ M ☐ I __________	☐ L ☐ D				#: ________ Ages: ________
		☐ F ☐ M ☐ I __________	☐ L ☐ D				#: ________ Ages: ________
		☐ F ☐ M ☐ I __________	☐ L ☐ D				#: ________ Ages: ________
If your biological father does not have siblings, please check here: ☐		☐ F ☐ M ☐ I __________	☐ L ☐ D				#: ________ Ages: ________
		☐ F ☐ M ☐ I __________	☐ L ☐ D				#: ________ Ages: ________
		☐ F ☐ M ☐ I __________	☐ L ☐ D				#: ________ Ages: ________
		☐ F ☐ M ☐ I __________	☐ L ☐ D				#: ________ Ages: ________
		☐ F ☐ M ☐ I __________	☐ L ☐ D				#: ________ Ages: ________

Other Relatives with Cancer

Please complete this page with information about any other biological family members diagnosed with cancer.

Initials	**Relationship to You**	**Sex assigned at birth** <u>F</u>emale, <u>M</u>ale, <u>I</u>ntersex *Note if this differs from gender identity*	**<u>L</u>iving or <u>D</u>eceased**	**Current Age or Age at Death**	**Cancer Diagnosis and Age at Diagnosis**	**Other Medical Conditions (please include colon polyps, precancerous skin moles, breast biopsies)**
		☐ F ☐ M ☐ I ____________	☐ L ☐ D			
		☐ F ☐ M ☐ I ____________	☐ L ☐ D			
		☐ F ☐ M ☐ I ____________	☐ L ☐ D			
		☐ F ☐ M ☐ I ____________	☐ L ☐ D			
		☐ F ☐ M ☐ I ____________	☐ L ☐ D			
		☐ F ☐ M ☐ I ____________	☐ L ☐ D			
		☐ F ☐ M ☐ I ____________	☐ L ☐ D			
		☐ F ☐ M ☐ I ____________	☐ L ☐ D			
		☐ F ☐ M ☐ I ____________	☐ L ☐ D			
		☐ F ☐ M ☐ I ____________	☐ L ☐ D			
		☐ F ☐ M ☐ I ____________	☐ L ☐ D			

Your Personal Cancer History

Past Cancer History (please check any cancers you have been diagnosed with in the past) *Check here if you have never been diagnosed with cancer* ☐

☐ Bladder Cancer ☐ Bone Cancer ☐ Brain Cancer ☐ Breast Cancer ☐ Cervical Cancer
☐ Colorectal Cancer ☐ Esophageal Cancer ☐ Leukemia ☐ Lung Cancer ☐ Lymphoma
☐ Ovarian Cancer ☐ Pancreatic Cancer ☐ Prostate Cancer ☐ Skin Cancer ☐ Small Bowel Cancer
☐ Stomach Cancer ☐ Thyroid Cancer ☐ Uterine Cancer ☐ Other: ________________________

Have you ever been diagnosed with a hematologic malignancy or myelodysplastic syndrome? If so, please specify diagnosis: ___________________________

Have you ever had a bone marrow transplant from a donor (i.e., allogenic transplant)? ☐ Yes ☐ No ☐ Unsure

Cancer Treatment History

Type of Cancer	Type of Treatment	
___________________	Surgery	☐ No ☐ Yes, please specify type: ____________________
	Chemotherapy	☐ No ☐ Yes, please specify agents: ____________________
	Radiation	☐ No ☐ Yes, please specify area of body: ____________________
	Hormonal Therapy	☐ No ☐ Yes, please specify type: ____________________
	Other (specify)	____________________
	Where was your cancer treated?	____________________
___________________	Surgery	☐ No ☐ Yes, please specify type: ____________________
	Chemotherapy	☐ No ☐ Yes, please specify agents: ____________________
	Radiation	☐ No ☐ Yes, please specify area of body: ____________________
	Hormonal Therapy	☐ No ☐ Yes, please specify type: ____________________
	Other (specify)	____________________
	Where was your cancer treated?	____________________
___________________	Surgery	☐ No ☐ Yes, please specify type: ____________________
	Chemotherapy	☐ No ☐ Yes, please specify agents: ____________________
	Radiation	☐ No ☐ Yes, please specify area of body: ____________________
	Hormonal Therapy	☐ No ☐ Yes, please specify type: ____________________
	Other (specify)	____________________
	Where was your cancer treated?	____________________

MICHIGAN MEDICINE **Cancer Genetics** **Personal and Family History Questionnaire**	MRN: NAME: BIRTHDATE: CSN:

Your Personal Medical History

Past Medical History (check any medical problems you have been diagnosed with) *Check here if you have never been diagnosed with any of these medical problems* ☐

☐ Abnormal skin growths ☐ Benign tumors ☐ Collapsed lung ☐ Colon polyps ☐ Crohn's disease

☐ Hyperparathyroidism ☐ Kidney cysts ☐ Pancreatic cysts ☐ Pancreatitis ☐ Thyroid nodules

☐ Ulcerative colitis ☐ Uterine fibroids ☐ Other conditions you want us to be aware of: _____

Past Surgical History (check any surgeries you have had) *Check here if you have never had any of these surgeries* ☐

☐ Brain surgery ☐ Breast surgery ☐ Colon surgery ☐ Hysterectomy (uterus) ☐ Kidney surgery

☐ Ovary removal (one ovary) ☐ Ovary removal (both ovaries) ☐ Pancreas surgery ☐ Parathyroid surgery ☐ Prostate surgery

☐ Skin lesion excision ☐ Thyroid surgery ☐ Other surgeries you want us to be aware of: _____

Past Cancer Screening History (please check any screening you have had)

Part of Body	**Date of Last Screening and Location (hospital/doctor)**	**Any History of Abnormal Findings**
☐ Breast screening	Mammogram: _____ Breast MRI: _____	☐ No ☐ Yes (please specify) _____ Have you ever had a breast biopsy? ☐ No ☐ Yes
☐ Gastrointestinal screening (stomach, small intestine, colon)	Colonoscopy: _____ Sigmoidoscopy: _____ Upper endoscopy: _____	☐ No ☐ Yes (please specify) _____ How many colon polyps have you had in your lifetime? _____
☐ Gynecologic screening	Pap smear: _____ Endometrial biopsy: _____	☐ No ☐ Yes (please specify) _____
☐ Prostate screening	Prostate specific antigen (PSA): _____ Digital rectal exam (DRE): _____	☐ No ☐ Yes (please specify) _____
☐ Skin screening	Dermatology evaluation: _____	☐ No ☐ Yes (please specify) _____
☐ Thyroid screening	Neck ultrasound: _____	☐ No ☐ Yes (please specify) _____
Other cancer screening you want us to be aware of: _____		

Reproductive or Hormone Use History (if applicable)

Age at first menstrual period: ____ Age at menopause: _____ Age at first live birth: _____ Number of live births: _____ Total number of pregnancies: _____

Have you ever used hormonal birth control or other hormone replacement therapy? ☐ No ☐ Yes (please specify type and number of years) _____

Frequently Asked Questions for the Cancer Genetics Clinic

Why was I referred to genetics? Most individuals we see are referred to us due to a personal or family history that is suspicious for inherited risk. This personal or family history can include:

- Cancers diagnosed at an earlier age than usual (typically diagnosed before age 50)
- Rare cancers
- Individuals with more than one type of cancer
- Multiple family member with the same or related types of cancers
- Personal or family history of a known hereditary cancer syndrome
- Non-cancer conditions, such as multiple colon polyps, hyperparathyroidism, or other benign tumors
- Results of genetic testing performed on tumor tissue

If you are still unsure of your reason for referral, please check with your referring physician.

What does the appointment entail? At your appointment, you will meet with a genetic counselor and/or physician to discuss your medical and family history. After this discussion, if genetic testing is indicated, the provider(s) will review the risks, benefits, and possible outcomes of genetic testing.

What information will I get from genetic testing? Genetic testing can identify individuals and families with hereditary cancer syndromes. It requires a blood or saliva sample. If you have a hereditary cancer syndrome, early detection and risk-reducing options are often available. These may include increased screening, preventative surgery, and/or medications. If you do not have a hereditary cancer syndrome, increased cancer screening may still be recommended based on your family history. Genetic testing may also provide information to family members regarding their risk of developing cancer.

What is a hereditary cancer syndrome? The cause of most cases of cancer is unknown. However, 5-10% of cancers occur because of an inherited condition called a hereditary cancer syndrome. Hereditary cancer syndromes are caused by a variant in a gene that can be passed down from generation to generation. Hereditary cancer syndromes can increase the risk for various cancers.

Is genetic testing done the same day at the appointment? If genetic testing is indicated, a blood draw for the genetic test can be completed following your appointment. If you do not want to have the blood drawn the same day, it can be drawn at a later date. Genetic testing laboratories can often send an at-home saliva collection kit in the mail if you prefer this.

How long does it take to get genetic testing results back? It generally takes less than 4 weeks to get results but can take longer if your insurance requires pre-authorization or if very specialized testing is needed.

How will I receive the results of the genetic testing? A genetic counselor will call you with your genetic test results unless you prefer to be notified in-person.

MICHIGAN MEDICINE **Cancer Genetics** **Personal and Family History Questionnaire**	MRN: NAME: BIRTHDATE: CSN:

Where are you located? Our clinic is located in the Rogel Cancer Center, Floor 1 at 1500 E Medical Center Drive. Please park in P1.

Where do I send my new patient packet or medical records? See options below. *Please keep a copy of your paperwork if you are sending it via mail and please allow at least ten days for mail delivery.*

- Fax: 734-763-7672
- Scanning and emailing: cc-genetics@med.umich.edu (secure email)
- Mail: Genetics Intake Coordinator, Michigan Medicine, NCAC Cancer Call Center, 2901 Hubbard Road, Room 1621, Ann Arbor, MI 48109

Do I need a referral from my physician? Our clinic does not require a referral for you to be seen, however, your insurance may require a referral to provide coverage for the appointment. If you are unsure, please contact your insurance company directly to ask about this.

Does my insurance cover this?
Office visit: This visit is billed same as a specialty office visit and should be covered by your insurance. You may have a co-pay if your insurance required one. We have business service teams that work with the insurance companies with regard to any authorizations or referrals. Please contact Patient Financial Experience at 734-615-0863 with questions or concerns.
Genetic testing: There are many factors involved in determining whether genetic testing will be covered, including your specific insurance, your family and medical history, what tests may be ordered, and which laboratory is used. Those details will be discussed during the consultation. The procedure codes for genetic testing are not available in advance of your appointment. Genetic testing generally does not cost more than $250 out-of-pocket if not covered by insurance, but this varies.

How long does the appointment take?
The appointment takes about 1 to 1 ½ hour. Returning the enclosed new patient packet at least 2 weeks in advance of your appointment date will save time on the day of the appointment.

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: http://www.med.umich.edu/i/him/ROI/index.html

*** 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

MICHIGAN MEDICINE

REQUEST FOR OUTSIDE RECORDS - PATIENT INFORMATION FROM ANOTHER ORGANIZATION
(Authorization to Request)

For Clinic Use Only:
Date Request Sent: _____
☐ Mailed ☐ Faxed
Sent by: _____
Name Title Clinic/Unit
Information Received:
☐ No ☐ Yes - **Date Received:** _____
Received by:
_____
Name Title Clinic/Unit

This authorization is voluntary. I understand that Michigan Medicine (MM) will not condition treatment, payment, enrollment, or eligibility for benefits on my signing this document.

Patient Name: _____ **Maiden/AKA:** _____ **Date of Birth:** _____

Street Address: _____ **UMHS MRN:** _____

City/State/Zip: _____ **Telephone #:** _____

Email Address: _____

1. I hereby authorize the release of information from following Doctor / Clinic / Unit:

Name of Person/Organization: _____

Street Address: _____

City/State/Zip: _____

Send information to:

UMHS Doctor / Clinic / Unit: _____

ATTENTION (Name): _____ Phone #: _____

Address: _____ Fax #: _____

City/State/Zip _____

UMHS Doctor / Clinic / Unit: _____

ATTENTION (Name): _____ Phone #: _____

Address: _____ Fax #: _____

City/State/Zip _____

2. Specific Information Needed: From Dates of Service: _____/_____/_____ **to** _____/_____/_____
(mm/dd/yyyy) (mm/dd/yyyy)

***[To release alcohol and substance use disorder/treatment information, complete this form and Form 70-10232**.] I request the following information to be released, which may include: Psychological and social work counseling; HIV or AIDS or ARC; communicable disease or infections, including sexually transmitted disease, venereal disease, tuberculosis and hepatitis; and demographic information, for the purposes and conditions designated on this form.*

☐ Inpatient Record ☐ Consults ☐ Emergency Room Record ☐ Pathology
☐ Outpatient Record ☐ Treatment Summary ☐ Entire Medical Record ☐ X-Ray - Imaging Films/CD
☐ Operative Report ☐ Discharge Summary ☐ Laboratory Tests Results ☐ X-Ray - Imaging Reports
☐ Other (*specify*): _____

If outside records include diagnostic images (MRI, CT Scan, etc.) and a Michigan Medicine physician is required to "Re-Read" the image(s), there could be additional costs not covered by insurance. Please check with your insurance to determine any costs.
_____*(Initials Required)*

3. Purpose of Release/Disclosure: At the request of the patient (or patient's legally authorized representative); *for continuing care.*

4. This authorization expires on: _____ (*specify expiration date or event*)**.**
If left blank, the authorization will expire six (6) months after the date signed below.

5. Revoking authorization: I may revoke (cancel) this authorization at any time. Revocations (cancellations) must be made in writing and sent to the releasing organization. Revocations will not apply to information that already has been released.

6. Effect of release: Once information has been disclosed, it may no longer be protected from further disclosure by federal or state privacy laws.

_____ _____/_____/_____
Signature of Patient or Legally Authorized Representative (if patient is a minor or unable to sign) **DATE** (mm/dd/yyyy)

_____
Printed Name of Legally Authorized Representative (if patient is a minor or unable to sign)
Relationship to Patient: ☐ **Spouse** ☐ **Parent** ☐ **Next-of-Kin** ☐ **Legal Guardian** ☐ **DPOA for Healthcare**