UNIVERSITY OF MICHIGAN HOSPITALS & HEALTH CENTERS Authorization to Allow Electronic Access to my Electronic Health Record (EHR)	*UMHHC MRN: ☐☐☐☐☐☐☐☐☐ *PATIENT NAME: *BIRTHDATE:

1. **Authorization and Purpose:** I authorize or give permission for the Organization named below, and its physicians/staff as deemed appropriate to view/access my medical records stored electronically at the University of Michigan Hospitals & Health Centers (UMHHC) for the purpose of my continued medical treatment. **I understand that I am not required to sign this authorization**, and both the UMHHC and the Organization named below will not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this document.
2. **Health information accessed:** I understand that this authorization is for read-only access to my medical records maintained electronically by UMHHC, which may include my medical records from other physicians, hospitals and clinics outside of UMHHC, and may include alcohol and drug abuse/treatment, psychological and social work counseling; HIV, AIDS or ARC; communicable disease or infections, including sexually transmitted diseases, venereal disease, tuberculosis and hepatitis; genetic information and demographic information for the purposes designated on this authorization.
3. This authorization does not expire unless I revoke (cancel) it.
4. **Revoking (cancelling) authorization**: I may revoke this authorization at any time. Revocations must be made in writing and sent to:

   UMHHC Health Information Management
   Electronic Health Record (EHR) Access Specialist
   2901 Hubbard Rd, Room 2121
   Ann Arbor, MI 48109-2435

   Revocations will not apply to information that already has been released. If this authorization was obtained as a condition of providing insurance coverage, the authorization will not apply to my insurance company to the extent the law provides my insurer with the right to contest a claim under the policy, or the policy itself.
5. Note: By signing this document, information will be disclosed by UMHHC to the Organization listed below. While the potential for information disclosed could be subject to re-disclosure by the recipient and to no longer be protected by HIPAA, the Organization listed below is obligated to maintain the confidentiality of the information.
6. *Organization name: Tree of Life Wellness, PLC

   *Street address: 3830 Packard St, Suite 230

   *City, State & Zip: Ann Arbor MI 48108

   *(Area code) Phone number: 7343302110

_____ ____/____/_____
***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**

*Required information

The patient signed authorization will be maintained in the UMHHC electronic health record (EHR). Please fax completed authorization to 734-232-1230 without a coversheet.

70-10167	VER: A/14 HIM: 6/14	UMHHC Medical Record	University of Michigan Hospitals and Health Centers	Authorization to Allow Electronic Access to my Electronic Health Record (EHR)

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