MICHIGAN MEDICINE
UNIVERSITY OF MICHIGAN
LABORATORIES

AUTHORIZATION TO RELEASE COPIES OF A MEDICAL RECORD

Patient Name: _____ **Date of Birth:** _____
Street Address: _____
City: _____ **State:** _____ **Zip:** _____
Telephone #: _____ **E-mail Address:** _____

☒ I am the patient, or the legally authorized representative of the patient listed above and request Michigan Medicine Laboratories to release my protected health information (or the patient information listed above) to the E-mail address listed above.

I request the following information be released:

☒ COVID-19, PCR Test Results

This authorization expires 30 days after the date of signature

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

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

*****Please Sign and Return this Form with Your Specimen*****
Results will be E-mailed to the address listed as soon as testing is complete.
Michigan Medicine Laboratories -Toll Free 800-862-7284