

Dear Dr.,

The Detroit Medical Center is going to make it easier for you to receive information about the patients you refer to us! We hope you choose to take part in the DMC auto-faxing program by filling out and signing the enclosed enrollment application.

In completing the application below, please provide one location that you would like your patient's health information transmitted (ie. the one secure fax location to send documents). If you choose, you will be notified of patient visits to the Emergency Department, admissions to the hospital and other transcribed information after discharge. We will also provide contact information of the providers caring for your patients.

The security of patient health information is paramount in the process. You will not be officially enrolled until we've verified the information you have provided us and have confirmed through testing your fax number. Please fax, email or mail the DMC auto Fax Enrollment Application as soon as possible to:

Health Information Management

Attn: Leah K. Harris

4707 St. Antoine Street

Rm-W-383

Detroit, MI 48201

313-745-7660 or 313-745-6587 phone

313-745-1530 or 313-745-9963 fax

LHarris5@dmc.org email

DMC AUTO-FAX ENROLLMENT APPLICATION

Physician's Full Name: _____

Office Address: _____

City & Zip Code: _____

Office Phone Number: _____

Office Fax Number: _____

Office Contact Person: _____

I wish to receive: ___Admit Notice ___CHM Orthopedic Clinic ___Clinic Letter ___Discharge
Summary ___ED Visit Notice ___Emergency Treatment Note ___*Hem Onc
Progress Note ___*Karmanos ___Operative Notes ___Physician
Communication ___*ROC Completion of Treatment Summary ___*ROC Follow-
up Note ___*ROC New Patient ___Radiology

***Radiation, Oncology Cancer**

Send NO documents via Auto Fax: (Please Check Here) _____

My signature below indicates my desire to be enrolled into the Detroit Medical Center Auto-fax Program. I understand and agree to abide by the conditions of the program as set forth below and as they may be amended from time to time.

Physician's Signature: _____

Date: _____

Terms and Conditions

The Detroit Medical Center created the auto-faxing program for the benefit of DMC patients and their referring physicians. The enrolling physician agrees to keep the information requested above current. The physician also agrees that he/she will immediately notify the DMC in the event he/she receives information concerning a patient with which he/she does not have a treating relationship. The enrolling physician agrees to participate in all fax testing procedures, which may be required of him/her to assure the accuracy in the transmittal of information.