Dear Dr.,

The Detroit Medical Center is going to make it easier for your 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 porcess. You will not be officially enrolled untill 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](mailto: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.***

Please **fax,** **email** or mail the DMC Auto Fax Enrollment Application to:

Health Information Management

Attn: Leah Harris

4707 St. Antoine Street

Rm. W-383

Detroit, MI 48201

313-745-6587 phone

313-745-9963 **fax**

[**lharris5@dmc.org**](mailto:lharris5@dmc.org) **email**

**DMC AUTO-FAX ENROLLMENT *CONFIRMATION***

Attention: \_ **Office Contact \_\_\_\_\_\_\_**\_\_ of Dr. \_ \_\_\_\_\_\_\_\_\_\_\_\_\_ ’s Office

We have received your application to the DMC Auto-Fax Program.

Please fax, **email** or mail this ***CONFIRMATION*** to:

Health Information Management

Attn: Leah Harris

4707 St. Antoine St.

Room W-383

Detroit, MI 48201

313-745-6587 phone

313-745-9963 **fax**

[**lharris5@dmc.org**](mailto:ksmith4@dmc.org) **email**

Any Changes? Indicate below:

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 all information provided to the Detroit Medical Center Auto-fax Program is accurate and complete. 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.

**Office Contact, please sign here.**

**\***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.*