UAB Health System

UAB HEALTH SYSTEM – UAB Huntsville Regional Medical Campus
AUTHORIZATION FOR USE OR DISCLOSURE OF INFORMATION

I hereby authorize the use or disclosure of my individually identifiable protected health information ("PHI") as described below. This Authorization includes any information relating to drug and/or alcohol abuse/treatment, communications with psychiatrists or psychologists or records pertaining to sexually transmitted diseases, if they are a part of my medical record. I understand that this authorization is voluntary. Once this information has been disclosed, it may be subject to redisclosure and no longer be protected by federal privacy regulations.

Patient name: _____ **Medical Record Number:** _____

Patient SSN: _____-_____-_____ **Patient DOB:** _____/_____/_____

Persons/organizations providing the information:

_____

_____

_____

Persons/organizations receiving the information

_____

_____

_____

Specific description of information (including date(s)):

—Face Sheet	— Discharge Summary
—History and Physical	—Pathology report
—Emergency room record	—Diagnostic procedure notes
—Lab results	—Problem list
— Medication list	—X-ray Report (Dates)
—Clinic notes	—Dates of operative report
—Lab reports (Dates and types)	—Consultation reports from (please supply physicians name):
—Problem List	—Other: (please describe):

Purpose of Use or Disclosure:

This information for which I'm authorizing disclosure will be used for the following purpose:

—My personal records	—Other: (please describe):
—Sharing with other health care providers as needed	

Authorization Date or Event: _____

Please complete back portion! This form must be COMPLETED in full.

The patient or the patient's representative must read and initial the following statements:
I understand that I have a right to evoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

Initial: _____ I understand that I may revoke this Authorization at any time by notifying the UABHS Privacy Officer in writing, but if I do, it will not have any affect to the extent UABHS took action in reliance on the Authorization.

Initial: _____ I understand that UABHS may not condition the provision of treatment, payment, and enrollment in a health plan, or eligibility for benefits on signing this Authorization, except under the following circumstances:

- Participating in research projects can be conditioned on my signing an Authorization to use and disclose PHI in the research
- Initial enrollment in health plans can be conditioned on signing an Authorization for the health plan to review PHI to make eligibility determinations
- Furnishing healthcare services to me at the request of a third party can be conditioned on me signing an authorization for disclosure of the PHI to the third party requesting the treatment

This authorization will expire _____.

If I fail to specify an expiration date or event, this authorization will expire six months from the date on which it was signed.

I understand that once the above information is disclosed, it may be redisclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

Signature of patient or patient's representative: _____

Printed Name of patient:_____

Printed Name of patient's representative:_____

Relationship to the patient:_____

Date:_____