

AUTHORIZATION FOR USE, INSPECTION AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Please Note: This Authorization is not valid unless it has been filled out completely.

Patient Name: _____ Date of Birth: _____

Street Address: _____

City, State, Zip Code: _____ Telephone: _____

1. Information to be Disclosed-Covering the Periods of Health Care: *(There may be a fee for copying these records).*

From (date) _____ To (date) _____

- Discharge Summary
- Laboratory Results
- Radiology Reports only
- Radiology Films / CDs
- History and Physical Examination
- Operative Reports
- Progress Notes
- Itemized Bill
- Consultation Reports

Other _____
(please specify)

2. Purpose of Request:

- Treatment/Consultation
- Insurance copy
- Attorney
- Personal Copy
- Other _____

3. To Be Released From

To Be Released To

4. Drug and/or Alcohol Abuse, Communicable Disease, Psychiatric, and or HIV/AIDS/Genetic Testing Records Release:

I agree that any information regarding Drug and/or Alcohol Abuse, Communicable Diseases, Psychiatric, and/or Genetics Testing may be released. _____ No *(initials)*_____

I agree that any medical or billing record containing information in reference to HIV/AIDS (Human Immunodeficiency Virus/ Acquired Immunodeficiency Syndrome) testing and/or treatment may be released. _____ No *(initials)*_____

5. Time Limit & Right to Revoke Authorization:

I understand that I can revoke this authorization at any time by submitting a written notice to the Custodian of Records at the location where my records are located. However, I understand my records may have already been released.

6. Re-disclosure / Treatment/ Condition:

I understand that the information disclosed by this authorization may be subject to re-disclosure by the recipient and no longer be protected by the Health Insurance Portability and Accountability Act of 1996. UPH, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information. I understand I am not required to sign this Authorization as a condition to obtain treatment, payment of services or eligibility for benefits.

Signature of Patient or Personal Representative Who May Request Disclosure:

Signature: _____ Date: _____

Print: _____ Authority to sign if not Patient: _____

Identity of Requestor Verified:

- Photo ID
- Matching Signature
- Other: _____
(please specify)

Verified By: _____



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Protected Health
Information**