University Medical Center

Updated as of 6/16
Supersedes all prior versions

Authorization to Disclose Health Information

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

Patient Name: ______________________________________ Date of Birth: ____________________________ Medical Record # ____________

Patient Telephone #: ____________________________________ Social Security #: ____________________

Please request my medical records from: Name: ____

Address: ____

____

Phone #: _________________________ Fax #: ________________________

Please send my medical records to: Name: ____

Address: ____

Phone #: _________________________ Fax #: ________________________

Please send/request this information: Office Note: ______Lab: _____Medications: ______Immunizations: ______

Other: ________________Please specify: ____________________________ Entire record: _____________

From what time period do you want information released or obtained: ______________________________________

This information will be used by: self: _____ physician: ________ other: __________

Please send this information by: Mail: ( ) yes ( ) no Fax: ( ) yes ( ) no Telephone: ( ) yes ( ) no
Email ( ) yes ( ) no ( ) Encrypted ( ) unencrypted Patient has been informed of risk

This authorization will expire: ____
Note: After this date has passed, this authorization will no longer be valid. Unless otherwise specified this authorization will be valid for 6 months after the date it is signed. If the authorization is for research, the statement "end of the research study" or "none" or similar language will extend your permission beyond 6 months.

Unless explicitly excluded, 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 re-disclosure and may no longer be protected by federal privacy regulations.

If for marketing, will UMC receive payment/benefit from the third party receiving the PHI? __Yes __No __N/A

The patient or the patient's representative must read and initial the following statements:

Initials: _________ I understand that I may revoke this Authorization at any time by notifying UMC Privacy Officer in writing, UMC will not be liable for any protected health information released prior to me revoking this authorization.

Initials: _________ I understand that UMC may not condition the provision of treatment, payment, 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.**

If a third party request healthcare services for me, PHI will not be released without me signing an authorization.

Signature of patient or patient's representative: ____________________________________ Date: _________________

Printed name of patient's representative: ____

Relationship to patient/description of authority to act for patient: ____