UAB HEALTH SYSTEM

Knowledge that will change your world

UAB HEALTH SYSTEM – University Hospital, The Kirklin Clinic at Action Road, UAB Health Centers, the University of Alabama Health Services Foundation P.C. (Health Services Foundation) and community physicians who are on the UAB Health System Medical and Dental Staff pursuant to the UAB Health System Medical and Dental Staff Bylaws.

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 psychologist 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 no longer be protected by federal privacy regulations.

Patient Name:________________________

Patient SSN:__________-__________-_________

Patient's Phone Number:_(_____)_______________

Medical Record Number:_________________

Patient DOB:________/_________/________

Patient's Address:_______________________

City, State, ZIP:_________________________

Persons/Organizations providing the information:

Name:_________________________________

Address:_______________________________

City, State, Zip:___________________________

Phone:_________________________________

Persons/Organization receiving the information:

Name:__________________________________

Address:_______________________________

City, State, Zip:___________________________

Phone:_________________________________

Specific description of information (including date(s):

___Face Sheet

___History and Physical

___Emergency room record

___Lab report(s) (dates)

___Medication list

___Clinic notes

___Consultation reports from (please supply Physicians name):

___Other: (please describe):

___Discharge Summary

___Pathology report

___Diagnostic procedure report(s) (dates & types)

___Problem list

___X-Ray report(s) (dates)

___Operative report(s) (dates)

<u>Purpose of Use or Disclosure:</u>

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

_____My personal records

_____Sharing with other health care providers as needed

_____Other: (please describe):

This patient or the patient's representative must read and initial the following statements:
I understand that I have a right to revoke 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 entity privacy coordinator. 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 effect to the extent to 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 treatment

This authorization will expire ________________________________.
(date of event)
If I fail to specify an expiration date or even, this authorization will expire in six months from the date on which it was signed.
Signature of patient or patient representative:____
Printed Name of patient:____
Printed Name of patient's representative:____
Relationship to the patient:____
Date:____

<u>Office use only:</u>
Distribution copies: Original to provider; copy to patient; copy to accompany use or disclosure
Use or Disclose Health Information
Patient Name:____
Medical Record Number:____
Date of Birth:____