UAB Health System

UAB HEALTH SYSTEM – University Hospital, The Kirklin Clinic, The Kirklin Clinic at Acton 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 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 no longer be protected by federal privacy regulations.

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

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

Patient's Phone #: (___)_____ **Patient's Address:** _____

City, State, Zip: _____

Persons/organizations providing the information:

Name: _____

Address: _____

City, State, Zip_____

Phone: _____

Persons/organizations 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)

Purpose of Use or Disclosure:

This 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):

The 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 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 _____.
(date of event)

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

Signature of patient or patient's representative: _____

Printed Name of patient:_____

Printed Name of patient's representative:_____

Relationship to the patient:_____

Date:_____

Office use only:

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: _____