UAB HEALTH SYSTEM

UAB HEALTH SYSTEM – UAB Hospital, The Kirklin Clinic of UAB Hospital, The Kirklin Clinic of UAB Hospital at Acton Road, UAB Health Centers, the University of Alabama Health Services Foundation P.C. (Health Services Foundation) owned and operated clinics, 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 PATIENT INFORMATION

I hereby authorize the use or disclosure of my 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: ________________________________

Patient Birthdate: ________/________/______________

Patient SSN: __________-________-______________

Patients Address: ________________________________

Patients Phone: (_________) ____________________

City, State, Zip: ________________________________

Alternate Phone: (_________) ____________________

Medical Record Number: __________________________

This authorizes the following Physician and/or Facility/Clinic:

____

to disclose information as specified below for the following purpose(s): ☐ **my personal use**

☐ **sharing with other health care providers as needed**

☐ **other (describe):** ______________________________

Person/Organization receiving information:

☐ **Check if same as above (disclosure to patient)**

Name: ____

Address: ____

City, State, Zip: ___________________________________

Phone: ____

Fax: ____

Specific information requested:

___ **Face Sheet** (from _________to________)

___ **History and Physical** (from _________to________)

___ **Emergency room record** (from ________to_______)

___ **Lab report(s)** (from _________to________)

___ **Medication list** (from _________to________)

___ **Clinic notes** (from _________to________)

___ **Consultation reports from (supply physician's name)**_______________________________________: (from _________to________)

___ **Radiology Films** (from _________to_________)

___ **Discharge Summary** (from _________to_________)

___ **Pathology report** (from _________to_________)

___ **Diagnostic procedure report(s)** (from _________to_________)

___ **Problem list** (from _________to_________)

___ **X-ray report(s)** (from _________to_________)

___ **Operative report(s)** (from _________to_________)

___ **Billing Records** (from _________to_________)

___ **Fetal Monitors** (from _________to_________)

___ **Other: (Describe and include dates of service):** ____

Media Type: ☐ **Electronic** ☐ **Paper**

Delivery Preference: ☐ **Mail** ☐ **Pickup** ☐ **CD** ☐ **Fax (another healthcare provider only)**

☐ **Email/Secure Portal:** ____

NOTICE: If I request records in electronic form, I understand that the records on the CD or available via email/secured portal will be encrypted to help protect my privacy and the security of my health records and that I will be furnished with the manner in which to access those encrypted records. UAB Health System is not responsible for the privacy and security of the electronic records on the CD or in an email once they are received by the intended recipient.

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 effect 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: ____