

## 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 request includes any information relating to drug, alcohol use/treatment, communications with psychiatrists or psychologists, and 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 regulations.

### Patient Information (please print)

Patient Name: \_\_\_\_\_ Patient Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_

Patient Street/Mailing Address: \_\_\_\_\_

City, State, and Zip: \_\_\_\_\_ Patient Phone: \_\_\_\_\_

UAB Medicine should provide records to \_\_\_\_\_ me for my personal use or to \_\_\_\_\_ the party indicated below:

Name of person/organization receiving my information: \_\_\_\_\_

Street address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_ Zip: \_\_\_\_

**Are you requesting psychiatric or substance use records to be included in the release?** Yes No

Date range for records: From \_\_\_\_\_ to \_\_\_\_\_ OR specific date: \_\_\_\_\_

(If no date is listed, records for the past 12 months will be provided.)

**If your records are going to another provider, please check here and they will be provided with the continuity of care/treatment package. (Includes key clinical notes, medication list, and histories.)**

### Select the record package that best meets your need for this Authorization:

Package 1 - Key Clinical Notes: Current history and physical, discharge summary, operative reports, outpatient clinic notes, Emergency Department provider documentation.

Package 2 - Clinical Notes: Package 1 plus medication list.

Package 3 - Clinical Notes II: Packages 1 and 2 plus diagnostic reports and laboratory test results.

Package 4 - Laboratory test results, Radiology reports, and other diagnostic reports.

Package 5 - Entire Medical Record: Package 3 plus nursing documentation. Excludes Fetal Monitoring strips- if needed, please select below.

**If you selected Package 1, 2, 3, 4, or 5 above, the following documentation, except billing records, Fetal Monitoring, and Radiology images, will be included in your selected package. However, if your request is specifically for any of the following only, please check the appropriate box(es):**

Operative/Procedure Report(s)                      Emergency Department Documentation/Discharge Summary

Outpatient Clinic Notes                      Billing Records                      Medication List

Fetal Monitoring Strips

Radiology Images: Please specify images needed: \_\_\_\_\_

Other specific record needed: \_\_\_\_\_

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### Records Delivery (select one)

#### Paper:

Mailed to address on this Authorization.

Pick up by \_\_\_\_\_

#### Electronic:

Faxed to number: \_\_\_\_\_

CD (mailed only to address on this Authorization)

Email to address: \_\_\_\_\_

**NOTICE:** If I request records in electronic form, I understand that the records will be encrypted to help protect my privacy and the security of my health records and that I will be furnished with the information on how to access those encrypted records. UAB Medicine 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 acknowledge the following statements by initialing each blank:

I understand that I may revoke this Authorization at any time by notifying the entity privacy coordinator in writing, but if I do, it will not be effective for disclosures made prior to my revocation in reliance on the Authorization.

I understand that UAB Medicine 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:

- Participation 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 on:** \_\_\_\_\_.

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 personal representative: \_\_\_\_\_

Printed name of patient: \_\_\_\_\_

Printed name of personal representative: \_\_\_\_\_

Relationship to the patient: \_\_\_\_\_ Date: \_\_\_\_\_

#### Return Completed Form:

UAB Health Information Management  
Release of Information Office  
1201 11<sup>th</sup> Ave. South  
Birmingham, AL 35205  
Fax: 205-930-6721