AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

(Not for Research or Marketing Use)

Please fill in the following information:

Patient Name:		
Birth Date:	**SS#**	
Patient Address:		
City:	**State:**	**Zip Code:**
Home Phone Number:	**Work Phone Number:**	

Check one:

□ Hospital Record □ Physician/Medical Practice Records:____
□ Discharge Summary □ Laboratory Data □ Entire Medical Record □ Abstract Medical Record
□ Operative Report □ EKG □ Emergency Room Record □ Pathology Report
□ X-Ray Report □ Other (specify)____

I authorize University Health Care System (University) together with its employees, agents and contractors, to use or disclose the above individual's protected health information (PHI) covered under the regulations pursuant to the Health Insurance Portability and Accountability Act of 1996 concerning the period from ______________ to ________________ as described below.

I understand that PHI may include information protected under law, such as alcohol or drug abuse treatment information, mental health related communications or treatment information, or information regarding sexually transmitted diseases including HIV or AIDS testing or treatment. I understand that PHI may include health information records of the patient disclosed to University by other health care providers. This authorization does not limit University's ability to use and disclose this health information in accordance with University's Notice of Privacy Practices.

This information may be disclosed to the following individual or organization:______________________________

____

Address:____

I understand that I may revoke this authorization at any time by submitting a written revocation form provided by University to the Health Information Services department. I understand that the revocation will not apply to information that has already been released in response to this authorization. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: ___________________________. If I fail to specify an authorization date, event, or condition, this authorization will expire in 90 days.

I understand that authorizing the disclosure of this PHI is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment unless the provision of healthcare is for the purpose of creating PHI for disclosure to a third party (e.g. an employee physical exam). I understand that any disclosure of information carries confidentiality rules. If I have questions about disclosure of my health information, I can contact the director of Health Information Services or his/her designee at (706)774-5861.

I have read and understand this Authorization and my questions have been answered. I certify that I am the patient listed above or a person authorized to permit release of records on patient's behalf. I hereby release University and its officers, trustees, employees, and contractors from any liability arising in connection with the use or disclosure of my protected health information pursuant to this authorization.

____ ________________________
Print Patient Name or Patient's Representative Name Date

____ ________________________
Patient or Patient's Personal Representative Signature Basis or authority to sign for Patient