HOSPITAL PATIENT ACCESS / 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 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 may no longer be protected by federal regulations.

Patient Information (please print) ***Required Fields for Patient Access**

*Patient Name: _____ *Patient Date of Birth: _____

*Patient Street / Mailing Address: _____

*City, State, and Zip Code: _____

*Patient Phone Number: _____

***UAB Hospital-Callahan Eye should provide records to:** ☐ me for my personal use or ☐ the party indicated below:

*Name of person / organization receiving my information: _____

*Street Address: _____

*City, State, and Zip Code: _____

Date range for records: From: _____ to _____ OR specific date: _____

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

** Records to Include:

☐ Only UAB Hospital – Callahan Eye Records
☐ Both UAB Hospital – Callahan Eye Records and UAB Health System Records

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Delivery Method

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 Hospital-Callahan Eye 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.

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

☐ **Please check here if your records are going to another provider.**
They will be provided the Continuity of Care / Treatment package.

☐ **Package 1 - Key Clinical Notes:** Current History and Physical, Discharge Summary, Operative and/or Procedure Reports, Laser Center provider documentation, Lions Eye Clinic provider documentation and Emergency Department provider documentation

☐ **Package 2 - Entire Hospital Medical Record**

If you selected Package 1 or 2, the following documentation, except billing records, will be included in your 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
- ☐ Billing Records
- ☐ Medication List
- ☐ Discharge Summary
- ☐ Laser Center Documentation
- ☐ Lions Eye Clinic Notes

☐ Other specific record needed:_____

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 Hospital-Callahan Eye 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 patient *Date

Return completed form to:
UAB Hospital-Callahan Eye Release of Information Office
1720 University Boulevard
Birmingham, AL 35233
Phone: 205-325-8390
Fax: 205-325-8682