UAB MEDICINE 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 11th Ave. South
Birmingham, AL 35205
Fax: 205-930-6721