ROICOR

UC Health

Hospital/Facility _____

Telephone Number _____ **Fax Number:** _____

AUTHORIZATION FOR RELEASE OF PATIENT PROTECTED HEALTH INFORMATION

_____

_____

PATIENT INFORMATION

Last Name _____ First _____ Middle _____ Maiden _____

Address _____ City _____ State _____ Zip _____

Date of Birth _____ Last 4 digits Social Security No. _____ Phone _____

COPIES SENT TO

Agency/Hospital _____ _____ _____

Name of Person _____ **Title** _____

Street Address _____

City _____ **State** _____ **Zip** _____

PROTECTED HEALTH INFORMATION TO BE USED OR DISCLOSED

Check box to indicate PHI that may be used or disclosed:

Dates _____

- o Inpatient
- o Emergency Department
- o Physical Therapy
- o Same Day Surgery
- o Outpatient

Pertinent summary documents (*) from the above visits will be sent, unless specified reports are indicated below:

- o Face Sheet*
- o History & Physical
- o Consultation Reports*
- o Discharge Summary*
- o Operative Reports*
- o Pathology Reports*
- o Other_____
- o Lab Reports*
- o X-Ray Reports*
- o Diagnostic Images
- o Test Reports*
- o Therapy Reports
- o Emergency Treatment

OVER FOR SIDE 2 ➔

ROICOR

UC Health

REASON NEEDED

Please specify the reason for your request:

- o Medical care
- o Disability
- o At My Request/Personal Reasons
- o Legal Reasons
- o Insurance
- o Other _____

I understand that if the person/entity that receives the above protected health information is not a health care provider/health plan covered by federal privacy regulations, the protected health information described above may be re-disclosed by such person/entity and will likely no longer be protected by the federal privacy regulations.

I understand that I/my legal representative may revoke this authorization in writing at any time, except to the extent that action has been taken in reliance on this authorization. Written revocation must be sent to _____
(**fill in hospital or facility name and address where revocations must be sent)**

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits, unless the treatment is for research purposes or unless the provision of treatment is related solely to the disclosure of my PHI to a third party such as when requested by my employer.

EXPIRATION

This authorization will expire in 60 days unless otherwise specified (**insert date or specific event)** _____**.**

I hereby authorize the use or disclosure of my protected health information as described above. I authorize the hospital to release the protected health information concerning treatment, diagnosis, or testing of drug or alcohol abuse, drug-related conditions, alcoholism, psychiatric/psychological conditions, Acquired Immune Deficiency Syndrome (AIDS), and/or test for antibodies to the AIDS virus (HIV).

_____ _____
Patient/ Legal Representative* Date

*Reason Patient is unable to sign _____

*Describe scope of authority to act for patient _____

Provide guardianship, executor of estate, power of attorney papers

_____ _____
Witness Signature Date

Retain original copy in Medical Records. Copy to patient or legal representative.