



Authorization to Access, Inspect and/or Obtain a Copy of Health Information

Name: _____
LAST FIRST MIDDLE

Medical Record Number (MRN): _____ Date of Birth: _____

Address: _____
STREET CITY STATE ZIP CODE

Phone: (____) _____ Cell/Work Telephone Number: (____) _____

I hereby authorized University Health System to disclose my Protected Health Information to the following Designee:

RECIPIENT: Name of person or class of persons to whom University Health System may disclose my Health Information:

Address of the recipient or where my health information should be delivered:

CITY STATE ZIP CODE PHONE NUMBER

This information for which I am authorizing disclosure will be used for the following purpose:

- | | |
|---|---|
| <input type="checkbox"/> My personal records | <input type="checkbox"/> Attorney |
| <input type="checkbox"/> Continuity of care | <input type="checkbox"/> Insurance |
| <input type="checkbox"/> Other (please describe): | <input type="checkbox"/> Disability claim |

Type of information to be used or disclosed is as follows *(check the appropriate boxes and include other information where indicated).*

- | | | |
|---|--|---|
| <input type="checkbox"/> Entire Record | <input type="checkbox"/> Laboratory Reports | <input type="checkbox"/> Immunization Records |
| <input type="checkbox"/> Emergency Center Treatment | <input type="checkbox"/> Radiology Reports | <input type="checkbox"/> Alcohol / Drug Treatment |
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Pathology Reports | <input type="checkbox"/> Mental Health Information |
| <input type="checkbox"/> History and Physical | <input type="checkbox"/> Physician Orders | <input type="checkbox"/> HIV Related Information |
| <input type="checkbox"/> Operative Reports | <input type="checkbox"/> Progress Notes | <input type="checkbox"/> Other (please describe): _____ |
| <input type="checkbox"/> Consultation Reports | <input type="checkbox"/> Nursing Notes | |
| | <input type="checkbox"/> Detention Health Care Services (Contracted) | <input type="checkbox"/> With Audit Report |

Date of Treatment: _____ Date Range of Records: From: _____ To: _____

- I acknowledge and hereby consent to the release of information relating to: psychiatric records, psychotherapy notes, alcohol and/or drug abuse records; HIV/AIDS information; genetic testing, and/or sexually transmitted disease information. Please Initial _____
 If you do not wish to have released any of the categories of information described above, please specify: _____
- I understand this authorization will expire on (Date) _____ or 180 days from the date of this signed authorization.
- I understand if the recipient authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal and state privacy regulations.
- I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization, I must do so in writing and present my written revocation to the Medical Records Department. I understand the revocation will not apply to information that has already been released in response tot his authorization.
- I understand authorization for the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure health care treatment. I further understand that my health care and the payment of my health care will not be affected if I do not sign this form.

Signature of patient or legal representative Description of Authority Date

Identification verified by: Driver License Other picture ID (Name): _____ MR Staff Initials: _____