Authorization For Use or Disclosure of Protected Health Information/Access to Protected Health

Information

I, _____, **[Print Name of Individual (i.e., patient, resident or client)]** hereby authorize _____ **[Insert CHI Entity]** to use and/or disclose the individually identifiable health information as described below for the following patient:

Patient Name: _____ DOB: _____

Street Address: _____

City: _____ State: __ _____ Zip Code: _____

I authorize the following person(s) or organization to receive the information:

Name: _____

Street Address: _____

City: _____ State: __ _____ Zip Code: _____

Phone: _____ Fax: _____ Email: _____

The following individually identifiable health information may be used and/or disclosed:

Check (✓) all that apply:

- ☐ All Records
- ☐ Discharge Summary
- ☐ Inpatient Records
- ☐ Emergency Room Records
- ☐ Complications, and Procedures
- ☐ Abstracts
- ☐ Immunization (shot) Record
- ☐ Outpatient Clinic Notes
- ☐ Reports of Tests & X-rays
- ☐ Facesheets with Final Diagnosis
- ☐ Outpatient Records
- ☐ Consultation Reports
- ☐ History and Physical Records
- ☐ Physical Therapy Notes
- ☐ Other*: _____

* If authorization is for *marketing*, indicate if _____ will receive compensation in exchange for the use and/or disclosure of the PHI. ☐ YES or ☐ NO

Dates of treatment to be released: _____

I request the form of the information be ☐ Paper ☐ Electronic (CD/DVD) ☐ Electronic (Email)

Catholic Health Initiatives

MediCopy

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Information

I authorize the release of any information contained in the above records concerning treatment of drug or alcohol abuse, drug-related conditions, alcoholism, psychiatric/psychological condition, psychiatric/mental health treatment and/or HIV-related conditions.

Reason or purpose for the use and/or disclosure of the information:

_____

I understand a fee may be charged for copies of my medical record.

Prohibition on Conditioning of Authorization: _____ will not condition treatment on your signing this authorization, unless:

- You are receiving research-related treatment; or
- The only reason the facility is providing you with health care is to make a report to a third party, such as your employer (e.g., fitness to return to work) or school (e.g., P.E. physical).

Re-disclosure: I understand that the information used and/or disclosed according to this authorization may no longer be protected by federal privacy law (also known as HIPAA) and the recipient of your health information may potentially re-disclose it. However, under the Federal Substance Abuse Confidentiality Requirements, 42 CFR Part 2, the recipient may be prohibited from disclosing identifiable substance abuse information.

Expiration: This authorization will expire _____ (insert date, event or "once purpose stated above is served").

Revocation: I understand that I may revoke this authorization at any time by notifying _____ in writing by sending a letter to the CHI Entity specified on this release or completing the Revocation of Authorization form. I understand that if I revoke this authorization, it will not affect any actions that _____ took before it received my revocation letter. For example, _____ cannot rescind disclosures it has already made and may use my health information as necessary to bill and collect for services rendered.

This Authorization is binding: The statements made in this authorization are binding, controlling and I understand that they take precedence over statements made in the _____'s Notice of Privacy Practices.

SIGNATURE OF INDIVIDUAL OR PERSONAL REPRESENTATIVE **DATE**

Printed name of individual's personal representative, if applicable:

Rationale for serving as personal representative to the individual (e.g., parent, legal guardian):

FOR INTERNAL PURPOSES ONLY

When **[Insert CHI Entity]** is requesting an authorization to use health information for its own use, the following provision must be completed:

Staff Personnel:

Received by: _____ Date: _____

Was a signed copy provided to the individual? ___YES ___NO

Access approved? ___YES ___NO