

Authorization for Use and Disclosure of Protected Health Information

Patient Identification

Name: _____ Date of Birth: _____

Address: _____

Phone: _____ Social Security #: _____

Dept./Clinic Name: _____

Address: _____

Address: _____

Address: _____

Phone: _____

Information to Be Released -- Covering the Periods of Health Care

From: _____ (date) To: _____ (date)

From: _____ (date) To: _____ (date)

Purpose of Request
 Treatment or consultation

 At the request of the patient

 Billing or claims payment

 Other: _____

Please check type of information to be released:
 Pertinent Documentation

 History and physical

 X-ray reports

 X-ray films/images

 Complete health record

 Discharge Summary

 Photographs, videotapes

 EKG

 Complete billing record

 Operative Report

 Lab Results

 EEG

 Itemized bill

 Consultation reports

 Progress notes

 Other

If Other, (specify) _____

I, the undersigned, authorize and request this facility to: Release information to Obtain information from

Name: _____

Address: _____

Drug and/or Alcohol Abuse, and/or Psychiatric, and/or Psychological, and/or HIV/AIDS Records Release

I understand that my medical or billing record may contain information in reference to drug and/or alcohol abuse, psychiatric care, psychological care, sexually transmitted disease, Hepatitis B or C testing, HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome) testing and/or treatment, and/or other sensitive information, I agree to its release.

I understand that if I authorize the release of Drug & Alcohol Abuse treatment records (such as from Center for Addictions) that those records are protected by Federal Law. The Authorization for Release of Information form does not authorize redisclosure of medical information beyond the limits of this consent. Federal Law (42 CFR Part 2) for Alcohol/Drug abuse, prohibit information disclosed from records protected by this law from being redisclosed, even to the patient, without the specific written consent of the patient or as otherwise permitted by such law and/or regulations. A general authorization for the release of medical or other information is NOT sufficient for these purposes. Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Time Limit & Right to Revoke Authorization

Except to the extent that action has already been taken in reliance on this authorization, at any time I can revoke this authorization by submitting a notice in writing to the Site Privacy Coordinator at the above address. Unless revoked, this authorization will expire on the following date or event _____, or one year from date of signature, unless otherwise specified.

Re-disclosure

I understand that once information is released to the above named person or persons, my information may be subject to re-disclosure. I understand that once information is released, it may be redisclosed by the recipient and no longer protected by the federal privacy regulations. I understand that I do not have to sign this authorization, and my treatment or payment for services will not be denied if I do not sign this form unless it is for research-related treatments or provided solely to give information to a third party as specified under Purpose of Request. I can inspect or copy the protected health information to be used or disclosed. **I authorize CoxHealth to use and disclose the protected health information specified above.**

Signature: _____

(Patient, parent if the patient is a minor child, or guardian)

Date

Relationship to Patient: _____

Revised April 14, 2004

A copy of this authorization shall be as effective and valid as the original."

Identity of Requester Verified via:

 Photo ID, Matching Signature

 Other, specify: _____

Verified by: _____