UofL Health

❑ University of Louisville Hospital ❑ Peace Hospital ❑ Medical Center Northeast ❑ UofL Physicians: _____ (Name of Physician)
❑ Brown Cancer Center ❑ Peace Hospital - Geropsych ❑ Medical Center East
❑ Jewish Hospital ❑ Shelbyville Hospital ❑ Medical Center South
❑ Mary & Elizabeth Hospital ❑ Frazier Rehabilitation Institute ❑ Medical Center Southwest

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION ACCESS TO PROTECTED HEALTH INFORMATION

I.COMPLETE ALL SECTIONS, DATE, AND SIGN

I, _____ (print name), DOB_____, hereby authorize the above facility to disclose the following health information from my medical record.

II.FACILITY OR INDIVIDUAL TO RECEIVE MY PHI

Facility or Individual: _____ Facility Contact: _____

Address: _____ Contact No.: _____

City: _____ State: _____ Zip Code: _____

III.PHI TO BE DISCLOSED: (Check all that apply)

❑ All Records
❑ Progress Notes
❑ Mental Health Records
❑ Discharge Summary
❑ History & Physical
❑ Psychosocial Assessments
❑ PT/OT Notes
❑ HIV/AIDS Records
❑ Operative Reports
❑ Sexually Transmitted Diseases
❑ Consent to Discuss Participation in Services
❑ Other:_____
❑ X-Ray Reports
❑ Consultations
❑ Alcohol/Drug Records
❑ Laboratory Results
❑ Emergency Records

IV.DATE(S) OF TREATMENT TO BE DISCLOSED

From Date: _____ To Date: _____ Expiration Date/Event: _____

V.REASON FOR DISCLOSURE

❑ Personal Use ❑ Attorney ❑ Legal/Court ❑ Further Medical Care ❑ Other_____

VI.FORMAT REQUESTED FOR DISCLOSURE

❑ Paper ❑ Electronic (CD Only) ❑ Fax: _____ ❑ Email: _____

VII.EXPIRATION OF AUTHORIZATION TO DISCLOSE PHI

If this authorization has not been revoked, it will expire ninety (90) days from the date of your signature unless a different expiration date or expiration event is provided above.

/III.REVOCATION, CONDITIONS AND RE-DISCLOSURE REQUIREMENTS

- I understand that I may revoke this authorization in writing submitted at any time to the Health Information Management Department, except to the extent that action has been taken in reliance on this authorization.

UofL Health, Attn: Release of Information 225 Abraham Flexner Way, Suite 650, Louisville, KY 40202

- I understand that the Hospital will not condition treatment on me signing this authorization, unless (a) I am receiving research-related treatment or (b) the only reason the health care is provided is to make a report to a 3rd-party, such as my employer (e.g. fitness to return to work) or school (e.g. P.E. physical).

- 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 that the recipient of my health information may potentially redisclose it; except for substance abuse information that may be prohibited by law (42 CFR Part 2).

_____ _____
SIGNATURE OF INDIVIDUAL OR PERSONAL REPRESENTATIVE DATE

_____ _____
Printed name of individual's personal representative, if applicable Title of personal representative to the individual

Witness:_____ Date:_____

RI0010

UofL Health

Instructions for Completing Authorization for Release of Information Form

1. Print legibly in all fields using dark permanent ink.

2. Section I: select the facility releasing medical records and print your name and date of birth or the name and date of birth of the patient whose health information is to be released.

3. Section II: print the name and full address of the facility/individual to receive the health information being released.

4. Section III: check the appropriate box as applicable to select the type of medical records you want released.
   a. **Other (specify)** –– e.g., Purchased Referred Care (PRC), Billing, Employee Health.
   b. **All Records** –– complete record including, if authorized, the sensitive information such as alcohol and drug abuse treatment/referral, sexually transmitted diseases, HIV/AIDS–related treatment, and mental health other than psychotherapy notes.
   c. **Consent to Discuss Participation in Services** –– if checked, gives your authorization for our caseworkers to discuss your progress and/or details about your participation in services or programs at our facility.

5. Section IV: enter the date range of medical records to be released. Specify date range, e.g., Jan. 1, 2002, to Feb. 1, 2002.

6. Section V: state the reason why the information is needed, e.g., court, continued medical care, etc.

7. Section VI: check the appropriate box to indicate the format in which to release the health records.

IN ORDER TO RELEASE SENSITIVE INFORMATION REGARDING ALCOHOL/DRUG ABUSE TREATMENT, HIV/AIDS–RELATED TREATMENT, SEXUALLY TRANSMITTED DISEASES AND/OR MENTAL HEALTH RECORDS (OTHER THAN PSYCHOTHERAPY NOTES), THE APPROPRIATE BOX OR BOXES MUST BE CHECKED BY THE PATIENT.

8. Please sign and date the Authorization Form.

9. A copy of the completed Authorization for Release of Information Form (UL840020) will be given to you.