PATIENT ACCESS/AUTHORIZATION FOR USE OR DISCLOSURE OF PATIENT INFORMATION

I hereby request/authorize the use or disclosure of my protected health information ("PHI") as described below. This Request/Authorization includes any information relating to drug, alcohol abuse/treatment, communications with psychiatrists or psychologists, and records pertaining to sexually transmitted diseases, if they are a part of my medical record. I understand that this Request/Authorization is voluntary. Once this information has been disclosed, it may be subject to re-disclosure and no longer be protected by federal regulations.

Patient Information (Please Print) *Required Access Request

*Patient Name: _____ *Patient Birthdate: _____

*Patient Address: _____ *City, State, Zip: _____

Patient Phone: _____ Alternate Phone: _____

*Patient SSN: _____ Medical Record Number (Office Use): _____

This authorizes the following UAB Medicine physician/facility/clinic, _____, to provide/disclose my records specified below to: ☐ me for my personal use or ☐ to the party indicated below:

Name of person/organization receiving my health information: _____

*Street Address: _____ *City, State, Zip: _____

Phone: _____ Fax (if applicable): _____

x	INFORMATION TYPE	DATE OF SERVICE FROM	TO
	Fact Sheet		
	History & Physical		
	Emergency Room Record		
	Lab Report(s)		
	Medication List		
	Clinic Notes		
Other Documents:			

x	INFORMATION TYPE	DATE OF SERVICE FROM	TO
	Discharge Summary		
	Pathology Report		
	Diagnostic Procedure Report(s)		
	Operative Report(s)		
	Fetal Monitoring		
	Billing Records		
	Radiology Film(s)		
	Consult Report(s)		
Physician Name:			

*PATIENT ACCESS REQUEST ONLY:

*NOTICE: If I request records in electronic form, I understand that the records will be encrypted to help protect my privacy and the security of my health records and that I will be furnished with the information on how to access those encrypted records. UAB Health System/UAB Callahan Eye is not responsible for the privacy and security of the electronic records on the CD or in an email once they are received by the intended recipient.

Media Type: ☐Electronic ☐ Paper

Delivery Type: ☐Mail ☐ Pickup ☐ CD ☐ Fax ☐ Email to: _____

UAB CALLAHAN EYE

The patient or the patient's representative must read the following statements:

I understand that I may revoke this Authorization at any time by notifying the entity privacy coordinator in writing, but if I do, it will not be effective for disclosures made prior to my revocation in reliance on the Authorization.

I understand that UAB Health System and UAB Callahan Eye may not condition the provision of treatment, payment, and enrollment in a health plan, or eligibility for benefits on signing this Authorization, except under the following circumstances:

- Participation in research projects can be conditioned on my signing an Authorization to use and disclose PHI in the research.
- Initial enrollment in health plans can be conditioned on signing an Authorization for the health plan to review PHI to make eligibility determinations.
- Furnishing healthcare services to me at the request of a third party can be conditioned on me signing an authorization for disclosure of the PHI to the third party requesting the treatment.

This authorization will expire:_____
(Date of event)

If I fail to specify an expiration date or event, this authorization will expire six months from the date on which it was signed.

*Signature of patient or patient's representative: _____

*Printed name of patient: _____

*Printed name of patient's representative: _____

*Relationship to patient: _____

*Date: _____