UAB-SCHOOL OF DENTISTRY
AUTHORIZATION FOR USE OR DISCLOSURE OF INFORMATION

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

Patient name: _____ **Medical Record Number:** _____

Patient SSN: _____-_____-_____ **Patient DOB:** _____/_____/_____

Patient's Phone #: (___)_____ **Patient's Address:** _____

_____

Persons/organizations providing the information:
Name: _____

Address: _____

City, State, Zip: _____

Phone: _____

Persons/organizations receiving the information
Name: _____

Address: _____

City, State, Zip:_____

Phone: _____

Specific description of information (including date(s):

____Face Sheet
____History and Physical
____Emergency room record
____Lab report(s) (dates)
____ Medication list
____Clinic notes
____Consultation reports from (please supply physicians name):

____ Discharge Summary
____Pathology report
____Diagnostic procedure report(s) (dates & types)
____Problem list
____X-ray report(s) (dates)
____Operative report(s) (dates)

____Other: (please describe):

Purpose of Use or Disclosure:
This information for which I'm authorizing disclosure will be used for the following purpose:
____My personal records

_____Sharing with other health care providers as needed

____Other: (please describe):

The patient or the patient's representative must read and initial the following statements:
I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the entity privacy coordinator. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

Initial: _____ I understand that I may revoke this Authorization at any time by notifying the UAB Privacy Officer in writing, but if I do, it will not have any affect to the extent UAB took action in reliance on the Authorization.

Initial: _____ I understand that UAB 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:

- Participating 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 the patient:_____

Date:_____

Office use only:

Distribution copies: Original to provider; copy to patient; copy to accompany use or disclosure

Use or Disclose Health Information

Patient Name: _____

Medical Record Number:_____

Date of Birth: _____