UAB HEALTH SYSTEM – University Hospital, The Kirklin Clinic, The Kirklin Clinic at Acton Road, UAB Health Centers, the University of Alabama Health Services Foundation P.C. (Health Services Foundation), physicians who are on the UAB Health System Medical and Dental Staff pursuant to the UAB Health System Medical and Dental Staff Bylaws.

AUTHORIZATION FOR USE OR DISCLOSURE OF INFORMATION for PAC

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 re-disclosure and no longer be protected by federal privacy regulations.

Patient Name: ______________________________

Patient SSN: _______- _____ - _______________

Patient's Phone: (______) ___________________

Medical Record Number: ____________________________

Patient DOB: ____________/__________/_______________

Patient's Address: ___________________________________

City, State, Zip: _____________________________________

Persons/organizations providing medical records:

Name: ____________________________________

Address: __________________________________

City, State, Zip _____________________________

Phone: (________) __________________________

Persons/organizations receiving medical records:

Name: ____

Address: ____

City, State, Zip _____________________________________

Phone: (________) ____________________________________

Specific description of information:

___Most recent electrocardiogram (ECG)
___Most recent treadmill stress test (GXT)
___Most recent echocardiogram (resting and stress)
___Most recent cardiac nuclear study (MIBI)
___Most recent cardiac catheterization
___Coronary artery stent placement (all)
___Most recent pacemaker/ICD interrogation (mode, reason for placement, battery life, effect of magnet placement)
___Carotid ultrasound/Doppler studies
___Most recent pulmonary function tests
___Lab report(s) (from ________ to ________)
___Medication list (from ________ to ________)
___Clinic notes (from ________ to ________)
___Discharge Summary (from________ to ________)
___Problem List (from ________ to ________)
___X-ray report(s) (from ________ to ________)
___Operative report(s) (from________ to ________)

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
___Preoperative evaluation
___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 UABHS Privacy Officer in writing, but if I do, it will not have any affect to the extent UABHS took action in reliance on the Authorization.

Initial:_________I understand that UABHS 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:_____________________________