UAB The University of Alabama at Birmingham.

Student Health Services

Authorization for Use or Disclosure of Patient Information

I **hereby authorize the use or disclosure of my protected health information ("PHI") as described below.** This request includes any information relating to drug, alcohol use/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 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)

Patient Name: _____ Patient Birthdate: _____

Patient Street/Mailing Address: _____

City, State, and Zip: _____

Patient Phone: _____

Persons/organizations providing the information:

Name: _____

Address: _____

City, State, Zip: _____

Phone: _____

Persons/organizations receiving the information:

Name: _____

Address: _____

City, State, Zip: _____

Phone: _____

Are you requesting psychiatric or substance use records to be included in the release? ____Yes ___ No

Date range for records: From _____ to _____OR specific date: _____

(If no date is listed, records for the past 12 months will be provided.)

Select the types of records that best meet your need for this Authorization:

__ Operative/Procedure Report(s)

__ Outpatient Clinic Notes

__ Immunization records

__ Lab results

__ Pap and any Gyn pathology testing results

__ Billing Records

__ Medication List

__ Radiology Reports: _____

__ Other specific record needed: _____

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Records Delivery (select one)

__ **Paper:**

- ☐ Mail to address on this Authorization.
- ☐ Pickup by: _____

__ **Electronic:** Fax to number: _____

The patient or the patient's representative must read and acknowledge the following statements by initialing each blank:

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 Student Health Services 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 on: _____

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 personal representative: _____

Printed name of patient: _____

Printed name of personal representative: _____

Relationship to Patient: _____

Date: _____

Return Completed Form:

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