UL Hospital UL James Graham Brown Cancer Center

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

❑ **University of Louisville Hospital** ❑ **James Graham Brown Cancer Center**

I, _____ **[Print Name of Individual]**, Date of Birth:_____Last 4 digits of SSN:_____, hereby authorize **The above facility** to use and/or disclose my individually identifiable health information as described below:

I authorize the following person(s) or organization _____ to receive the information:
❑ On Paper ❑ In Electronic form (on a CD)

Street Address:_____Telephone # :_____

City:_____ State:_____ Zip Code:_____

The following individually identifiable health information may be used and/or disclosed:
Check ✔ all that apply:

❑ Discharge Summary
❑ History and Physical Records
❑ Physical Therapy Notes
❑ Other*:_____
❑ Facesheet
❑ Consultation Reports
❑ All
❑ Reports of Lab Tests
❑ Operative Reports
❑ Emergency Room Records
❑ Reports of X−rays

* Indicate if University of Louisville Hospital will receive compensation in exchange for the use and/or disclosure of the PHI: ❑ **YES** ❑ **NO**

Dates of treatment to be released:_____
❑ I authorize the release of any information contained in the above records concerning treatment of drug or alcohol abuse, drug−related conditions, alcoholism, psychiatric/psychological condition, psychiatric/mental health treatment and/or HIV−related conditions.

Reason or purpose for the use and/or disclosure of the information:
_____

I understand a fee may be charged for copies of my medical record

Prohibition on Conditioning of Authorization: University of Louisville Hospital will not condition treatment on your signing this authorization, unless:

- You are receiving research−related treatment; or
- The only reason the facility is providing you with health care is to make a report to a third party, such as your employer (e.g., fitness to return to work) or school (e.g., P.E. physical).

Re−disclosure: 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 the recipient of your health information may potentially redisclose it. However, under the Federal Substance Abuse Confidentiality Requirements, 42 CFR Part 2, the recipient may be prohibited from disclosing identifiable substance abuse information.

Expiration: This authorization will expire 90 days from the date signed.

Revocation: I understand that I may revoke this authorization at any time by notifying University of Louisville Hospital in writing by sending a letter to Health Information Management at

University of Louisville Hospital
Health Information Management
530 S Jackson Street
Louisville, KY 40201
ATTN: ROI

Telephone: (502) 562−3062

or completing the Revocation of Authorization form. I understand that if I revoke this authorization, it will not affect any actions that the facility took before it received my revocation letter. For example, the facility cannot rescind disclosures it has already made, and may use my health information as necessary to bill and collect for services rendered.

This Authorization is binding: The statements made in this authorization are binding, controlling and I understand that they take precedence over statements made in the hospital Notice of Privacy Practices.

_____ _____
SIGNATURE OF INDIVIDUAL OR PERSONAL REPRESENTATIVE **DATE**

Printed name of individual's personal representative, if applicable:_____

Rationale for serving as personal representative to the individual (e.g., parent, legal guardian):_____

Witness:_____ Date:_____

FOR INTERNAL PURPOSES ONLY

When University of Louisville Hospital is requesting an authorization to use health information for its own use, the following provision must be completed:

Staff Personnel:

Received by: _____

Date:_____

Was a signed copy provided to the individual? ❑ Yes ❑ No

Access approved? ❑ Yes ❑ No

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