**[*Name of Provider or Organization*]**

**Request for Access to/Authorization for Use and Disclosure of Protected Health Information**

PATIENT NAME:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

LAST FIRST MI MAIDEN OR OTHER NAME

DATE OF BIRTH:\_\_\_\_\_\_\_-\_\_\_\_\_\_\_-\_\_\_\_\_\_\_ FORMER NAME:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MEDICAL RECORD #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MO DAY YR

ADDRESS:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CITY:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_STATE:\_\_\_\_ZIP:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DAY PHONE:­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ EVENING PHONE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**I hereby authorize [*Insert name of organization*] to disclose my protected health information as indicated below to:**

❑ Mail to: ❑ Hold for pick up by:

NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_RELATIONSHIP: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ADDRESS:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CITY:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_STATE:\_\_\_\_ZIP:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PHONE: ­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ FAX: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\_**

**INFORMATION TO BE RELEASED:**

DATES:

❑ Discharge Summary \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ I specifically authorize the release of information relating to:

❑ History & Physical Exam \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ❑ Substance abuse (including alcohol/drug abuse)

❑ Progress Notes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ❑ Mental health or behavioral health

❑ Lab Reports \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ❑ HIV related information (AIDS related testing)

❑ X-Ray Reports \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ X \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

❑ Medication Records \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature of Patient or Personnel Representative Date

❑ Detailed Bill \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

❑ Other (specify content and dates):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PURPOSE OF DISCLOSURE:**

❑ Changing provider ❑ Consultation ❑ Insurance/Workers’ Compensation ❑ School ❑ Research ❑ At request of individual

❑ Legal (specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

❑ Other (specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

❑ For personal access (specify): ❑ Copy ❑ Inspection ❑ Summary

**ACKNOWLEDGEMENT OF UNDERSTANDING:**

❑ I understand the expiration date of this authorization is ❑ \_\_\_\_\_\_\_\_\_\_\_ ❑ at end of research study ❑ not applicable for ongoing research

❑ I understand that I may revoke this authorization at any time by notifying the providing organization in writing, and it will be effective on

the date notified except to the extent action has already been taken in reliance upon it.

❑ I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer

be protected by Federal privacy regulations.

❑ By authorizing this use or disclosure of information, there will be no conditions placed on my health care or payment for my health care.

❑ I understand that if I am being requested to authorize a use or disclosure that I will get a copy of this form after I sign it.

❑ I understand my request will be acted upon within 30 days. If I am not provided access or information cannot be supplied, I understand I will

be notified, and have the right to request review of any denial of access other than those made in accordance with applicable law.

❑ I understand that I may be required to pay the cost of preparing and mailing copies, supervising my inspection, or preparing a summary

except for uses and disclosures for the purpose of treatment, payment, and operations.

Patient/Legal Representative Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Records Received by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ID VERIFIED:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

FOR OFFICE USE ONLY

DATE RECEIVED: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ FEE COLLECTED: $\_\_\_\_\_\_\_\_ DATE EXTENSION REQUESTED \_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE FILLED: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

WE ARE UNABLE TO COMPLY WITH YOUR REQUEST BECAUSE: REVIEWED BY:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

❑ The information you request was not created by [*Name of Provider*]. ❑ Access is denied in accordance with applicable law.

❑ Access is denied because such access may be harmful to you or someone else. You may request review of denial by contacting our Information Privacy Official.

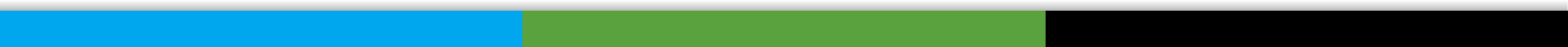
❑ Access to certain portions of the record must be denied; a summary or portions of the record is supplied instead.

YOUR REQUEST FOR REVIEW HAS BEEN PROCESSED:

An independent licensed healthcare professional has ❑ confirmed the need to deny your request ❑ recommended provision of access, as supplied

If you have any further questions or wish to file a complaint, please contact our Information Privacy Official. You may also request information about filing a complaint with the Secretary of Health and Human Services from our Information Privacy Official.

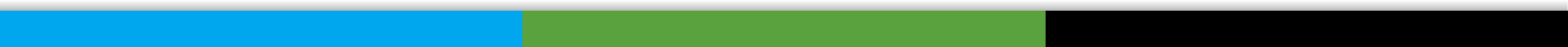
To contact our Information Privacy Official, call or write to: [*supply site name, address, and phone number and/or e-mail/web site*]



**Section 4.4 Implement—Authorization Form Template**

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