



**Authorization For Use or Disclosure of Protected Health Information/Access to Protected Health**

**ATTACHMENT B**

**Information**

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I, \_\_\_\_\_, **[Print Name of Individual (i.e., patient, resident or client)]** hereby authorize \_\_\_\_\_ **[Insert CHI Entity]** to use and/or disclose the individually identifiable health information as described below for the following patient:

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

I authorize the following person(s) or organization to receive the information:

Name: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Email: \_\_\_\_\_

The following individually identifiable health information may be used and/or disclosed:

Check (✓) all that apply:

- |  |  |
|--|--|
| <input type="checkbox"/> All Records                   | <input type="checkbox"/> Outpatient Clinic Notes         |
| <input type="checkbox"/> Discharge Summary             | <input type="checkbox"/> Reports of Tests & X-rays       |
| <input type="checkbox"/> Inpatient Records             | <input type="checkbox"/> Facesheets with Final Diagnosis |
| <input type="checkbox"/> Emergency Room Records        | <input type="checkbox"/> Outpatient Records              |
| <input type="checkbox"/> Complications, and Procedures | <input type="checkbox"/> Consultation Reports            |
| <input type="checkbox"/> Abstracts                     | <input type="checkbox"/> History and Physical Records    |
| <input type="checkbox"/> Immunization (shot) Record    | <input type="checkbox"/> Physical Therapy Notes          |
| <input type="checkbox"/> Other*: _____                 |  |

\* If authorization is for *marketing*, indicate if \_\_\_\_\_ will receive compensation in exchange for the use and/or disclosure of the PHI.  YES or  NO

Dates of treatment to be released: \_\_\_\_\_

I request the form of the information be  Paper  Electronic (CD/DVD)  Electronic (Email)

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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:

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

**Prohibition on Conditioning of Authorization:** \_\_\_\_\_ 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 re-disclose 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 \_\_\_\_\_ (insert date, event or “once purpose stated above is served”).

**Revocation:** I understand that I may revoke this authorization at any time by notifying \_\_\_\_\_ in writing by sending a letter to the CHI Entity specified on this release or completing the Revocation of Authorization form. I understand that if I revoke this authorization, it will not affect any actions that \_\_\_\_\_ took before it received my revocation letter. For example, \_\_\_\_\_ 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 \_\_\_\_\_’s Notice of Privacy Practices.

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**SIGNATURE OF INDIVIDUAL OR PERSONAL REPRESENTATIVE**

**DATE**

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

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

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***FOR INTERNAL PURPOSES ONLY***

When **[Insert CHI Entity]** 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