Patient MRN

Name

DOB

Patient stamp above - for HIM use only

UNIVERSITY UT CLINICAL HEALTH

Health Information Management - Medical Records
1407 Union Avenue, Suite 700
Memphis, Tennessee 38104-3600
901-866-8400 • Fax: 901-302-2400

Authorization to Obtain, Use, and/or Disclose Health Information

Please PRINT or TYPE and return completed form to the above address.

Patient Name: ____

Address: ____

City:______________________________ State: __________ ZIP: ____________________

Date of Birth: ___ / ____ / ______ Social Security Number: ____________________ Phone Number:____________________

1. I authorize UCH to obtain and/or disclose a copy of the health information described below (Please check ❑ To be **obtained from** or ❑ To be **disclosed to):**

____

Mailing Address: ____

City______________________________State: ________ZIP: ____________________

1(a). Information to be released: ❑ Complete medical record ❑ Laboratory results ❑ Progress notes

❑ Immunization record ❑ Other (specify) ____

1(b). Purpose or need for the information is ____

2. I understand that the information in my health record may include information relating to a sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

3. I understand that I can **revoke** this authorization at any time by sending my written request to: UCH Health Information Management Department at 1407 Union Avenue, Suite 700, Memphis, TN 38104-3600. Such written revocation will be effective only after receipt and processing by UCH. If I revoke this authorization, the information described above may no longer be used or disclosed for the purposes described in this authorization. I understand that the revocation will not apply to information that has already been obtained, used and/or disclosed under 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.

4. Unless revoked, this authorization will **expire** on the following date, event or condition: ______________________ If I fail to specify an expiration date, event, or condition, this authorization will automatically expire in six (6) months from the date of my request.

5. I understand that a disclosure of information under this authorization carries with it the potential for **re-disclosure** by the recipient and that the information may no longer be protected by federal confidentiality rules. If I have questions about the uses and disclosures of my health information at UCH, I can contact: UCH Privacy Officer at 1407 Union Avenue, Suite 700, Memphis, TN 38104-3673, Phone: (901) 866-8581, Fax: (901) 302-2581. I understand that I can refuse to sign this authorization. I need not sign this authorization in order to obtain treatment, payment, or health plan enrollment or eligibility.

6. I understand that I can refuse to sign this authorization. I need not sign this authorization in order to obtain treatment, payment, or health plan enrollment or eligibility.

______________________________ Signature of Patient or Personal Representative*

______________________________ Printed Name of Patient or Personal Representative*

______________________________ Date

______________________________ *Relationship to Patient (if Personal Representative)

*If Personal Representative, the patient is unable to sign because (check one):

❑ Minor ❑ Incompetent ❑ Other (explain): ____

For Office Use Only

Date received ____________________ ❑ All complete ❑ Proof of I.D. ❑ Signed copy to patient

Received by (*employee name*): ______________________________ Clinic Name: ______________________

Completed by (*employee name*): ______________________________ Clinic Name: ______________________

WHITE COPY - MEDICAL RECORD, YELLOW COPY - PATIENT