UofL Physicians

HIPAA AUTHORIZATION FOR RELEASE OF PATIENT INFORMATION

Section I – Patient Information

Name:	**Date of Birth:**
Street Address:	**Last 4 digits of SSN:**
City:	**State:**
Zip Code:	**Telephone:**

I, or my authorized representative, hereby authorize UofL Physicians employees, and subcontractors to disclose my Personal Health Information (PHI) to the designee identified below.

Section II – Authorized Designee (to whom the information will be sent or received from)

Where records are being sent to:		
Where records are requested from:		
Street Address:		
City:	**State:**	**Zip Code:**
Telephone:		

In accordance with the Health Insurance Portability and Accountability Act (HIPAA):

- I understand this authorization is voluntary. My treatment will not be impacted if I sign this authorization or not.
- I understand this authorization may include disclosure of information related to Alcohol and Drug Abuse, STD, Mental Health Treatment, except psychotherapy notes, and HIV information.
- I understand that if my PHI is disclosed to someone who is not required to comply with the Federal privacy regulations, then my information may be re-disclosed and would no longer be protected.
- I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to University of Louisville Physicians, Inc. (UofL Physicians) at the address listed below. I also understand that my request is not effective for actions already completed.

UL Physicians

- Unless otherwise revoked, I understand that this authorization will expire one hundred and eighty days (180) from the date on this form.

I understand that I have the right to refuse to sign this authorization.

I certify that I have received a signed copy of this authorization.

Section III - Information to be Released:

☐ My Medical Records from date: _____ to date: _____

☐ My entire Medical record

☐ Other: Please explain: _____

_____

_____

Section IV: Authorized Representative

If an authorized representative is making this request, please provide your information below and attach certifying documentation of your status as the authorized representative, such as Power of Attorney or Guardianship papers.

AUTHORIZED REPRESENTATIVE

Name:	
Street Address:	
City:	**State:** **Zip Code:**
Telephone:	

By signing this from, I am confirming that it accurately reflects my wishes. I have received a copy of this form for my records.

_____
Printed Name

_____ _____
Signature of Patient/Personal Representative/Guardian Date