UL Physicians

HIPAA AUTHORIZATION FOR THE USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

By signing this authorization form[1], I authorize disclosure of my/the patient's health information in the manner described below.

Patient Name: _____ Date of Birth: _____

Address: _____ Telephone Number: _____

I hereby authorize the use and/or disclosure of my protected health information as described below:

1. Only this information may be used and/or disclosed by this authorization. Records authorized to be released:
   _____
   _____

2. I understand that this information may include information relating to Acquired Immunodeficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV) infection, treatment for drug or alcohol abuse, or mental or behavioral health or psychiatric care.

3. The authorized person (or entity) who will receive the information indicated in this authorization is:
   _____

4. The protected health information being used and/or disclosed under this authorization is for the following purpose (you may leave this blank if you are the patient or the patient's legal guardian and the protected health information is being released to you.)
   _____
   _____

[1] HIPAA Authorizations are used for the following situations: Release of HIV/STD information, alcohol and drug abuse treatment, photos that include the individual's face and/or body parts, psychotherapy notes, research activities, certain marketing activities, sale of PHI, any use/disclosure not permitted by the HIPAA rules.

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5. I understand that if my protected health information 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

6. 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 on this authorization form. I also understand that my request is not effective for actions already completed.

7. Unless otherwise revoked, I understand that this authorization will expire one hundred and eighty days (180) from the date of this form or on the following date or event: _____

8. I understand that I do not have to sign this authorization as a condition of being treated by UofL Physicians.

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

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

Signature of Patient or Legal Representative _____ Date _____

(Must provide written proof of legal status)

If Legal Representative, Print Name _____

If Legal Representative, Relationship to Patient _____

Signature of Facility Representative _____ Date _____

Facility Name _____

Facility Address _____

Facility Phone _____