

Patient: _____
Address: _____
City, State, Zip: _____
Date of Birth: _____
Patient Phone Number: _____
Medical Record # (MRN): _____



Authorization to Access, Inspect and/or
Obtain a Copy of Protected Health Information
(Adolescent 13-17)

I give University Health permission to share my medical records with the following:

Self: See above information provided for recipient mailing address & contact information.

Recipient: _____
Name of person or organization to which disclosure of Protected Health Information is to be made

Recipient Address: _____
Street City State Zip Code

Recipient Phone Number: (____) _____ Recipient Fax Number: (____) _____

The following information is to be disclosed for the dates of treatment: _____ to _____

- | | | |
|--|---|--|
| <input type="checkbox"/> Pertinent Packet (H&P, Op, D'C, Labs, X-rays) | <input type="checkbox"/> Operative/Procedure Reports | <input type="checkbox"/> Immunization Record |
| <input type="checkbox"/> Face Sheet | <input type="checkbox"/> Laboratory Reports | <input type="checkbox"/> Consultation Reports |
| <input type="checkbox"/> Admit/Discharge Summary | <input type="checkbox"/> Pathology Reports | <input type="checkbox"/> Alcohol/Drug Treatment |
| <input type="checkbox"/> Emergency Room Treatment | <input type="checkbox"/> Radiology Digital Images | <input type="checkbox"/> HIV Related Information |
| <input type="checkbox"/> History & Physical | <input type="checkbox"/> Radiology Reports | <input type="checkbox"/> Entire Record |
| <input type="checkbox"/> Progress Notes | <input type="checkbox"/> Mental Health Info (<i>complete BCHD# 508</i>) | |
| <input type="checkbox"/> Other: _____ | | |

Disclosure of Protected Health Information will be used for the following purpose(s): Medical Legal Insurance
 At The Request of the Individual Other: _____

Disclosure of Protected Health Information can be delivered by: Mail In Office Pick Up Fax Other: _____

Disclosure of Protected Health Information can be provided by: (Check one) DVD (PDF) MyChart Paper

- I acknowledge and hereby consent to the release of information relating to: **psychiatric records, alcohol and/or drug abuse records, HIV/AIDS information, genetic testing, and/or sexually transmitted disease information.** If you do not wish to have released any of the categories of information described above please specify: _____
- I understand if the recipient authorized to receive the information is not a health plan or health care provider, the released information maybe re-disclosed and no longer be protected by federal and state regulations.
- I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization, I must do so in writing and present my written revocation to the Health Information Management Department. I understand the revocation will not apply to information that has already been released in response to this authorization.
- I understand that signing this authorization is voluntary. My treatment, payment, enrollment and eligibility benefits with University Health, will not be conditioned upon my authorization of disclosure.
- This authorization shall expire upon release of the information for the purpose stated above, or 180 days (six months) from the date of signature, whichever occurs first.
- A copy of the signed authorization will be provided to the recipient.

SIGNATURES

NOTE: IF PATIENT IS UNDER 13 YEARS OF AGE AND IS NOT AN EMANCIPATED MINOR THE PARENT OR GUARDIAN MUST SIGN. IF BETWEEN THE AGES OF 13-17 YEARS OF AGE, BOTH PATIENT AND PARENT/GUARDIAN MUST SIGN.

Signature of Adolescent _____ Date _____

Signature of Parent/Guardian _____ Relationship to Adolescent _____ Date _____

