HAHN OB-GYN

Request for Access/Authorization for Use and Disclosure of Protected Health Information

PATIENT NAME:_____
Last First MI Maiden or Other Name

DATE OF BIRTH:_____ADDRESS_____
_____PHONE:_____

I hereby authorize: to disclose my protected health information as indicated below to :

Name:_____ Name:_____
Address:_____ Address:_____
City,State, & Zip:_____ City,State,Zip:_____
Phone:_____Fax:_____ Phone:_____Fax:_____
_____Mail Hold for pick up by:_____

INFORMATION TO BE RELEASED:

_____Discharge Summary_____
_____History &Physical _____
_____Progress Notes _____
_____Lab Reports _____
_____X-Ray Reports _____
_____Medication Records_____
_____Detailed Bill _____
_____Consult Notes _____
_____Other (Specify content and dates):_____

I specifically authorize the release of info relating to:

___Substance abuse(including alcohol/drug)
___Mental health or behavioral health
___HIV related info(AIDS related testing)

_____
Signature of Patient or Personal Rep Date:

PURPOSE OF DISCLOSURE:

____Changing Physicians_____Consultation____Insurance/Workers Comp___School
____Research_____At Request of Individual.
____Legal (specify):_____
____Other (specify):_____
____For personal access(specify):_____Copy_____Inspection_____Summary

ACKNOWLEDGEMENT OF UNDERSTANDING:

Initial each line.

_____I understand the expiration date of this authorization is_____At the end of research study_____Not applicable for ongoing research_____.

_____I understand that I may revoke this authorization at any time by notifying the providing organization in writing, and it will be effective on the date notified except to the extent action has already been taken in reliance upon it.

_____I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by Federal privacy regulations.

_____By authorizing this use or disclosure of information, there will be no conditions placed on my healthcare or payment for my health care.

_____I understand that if I am requested to authorize a use or disclosure that I will get a copy of this form after I sign it upon request.

_____I understand my request will be acted upon within 30 days. If I am not provided access or information cannot be supplied, I understand I will be notified, and have the right to request review of any denial of access other than those made in accordance with applicable law.

_____I understand that I may be required to pay the cost of preparing and mailing copies, supervising my inspection, or preparing a summary except for uses and disclosures for the purpose of treatment, payment, and operation. The fee will not exceed current state limits.

Patient/LegalRepresentave

Signature:_____Date:_____Relationship:_____
Records Received by:_____Date:_____ID Verified_____