02-0018

UNIVERSITY HOSPITAL AND CLINICS

Authorization for the Use and Disclosure of Protected Health Information

Patient Name:	Date of birth:

Address: _____ Telephone No. ( )_____

City: _____ State: _____ Zip Code: _____

I hereby authorize _____ to disclose my individually
(facility or covered entity)
identifiable health information as described in this authorization to:

_____
Name/Title

_____
Address

Purpose of the disclosure:

_____
Specific description and time period of information to be disclosed:

_____

_____ I acknowledge, and hereby consent to, the release of protected health information regarding:
(initials) ____ alcohol abuse/treatment, ____ drug abuse/treatment, ____ psychiatric treatment/mental illness,
____ HIV/AIDS infection/treatment, ____ sexually transmitted diseases/treatment, ____ genetic testing.

- I understand that the information I authorize a person or entity to receive may be re-disclosed and no longer protected by federal privacy regulations.
- I understand that this authorization is voluntary and that I may refuse to sign. My refusal to sign will not affect payment for or coverage of services, or ability to obtain treatment.
- I understand that Louisiana law and regulations allow for fees/charges to be applied to this release of information.
- I understand that I may inspect or copy the information used or disclosed upon request.
- I understand that I may revoke this authorization at any time by notifying UHC in writing, except to the extent that:
  a.) action has been taken in reliance on this authorization
  b.) if this authorization is obtained as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy or the policy itself.
- I understand that I have a right to request and receive a Notice of Privacy practices from UHC upon request.
- I understand that I may receive a copy of this authorization upon request.
- I understand this release does not authorize verbal communications by UHC to the requesting party.
- The person/organization authorized to use/disclose the information will receive compensation for doing so.
  _____Yes _____No

This authorization will expire on: Date: _____

I have read the above and authorize the disclosure of the protected health information as stated.

_____ _____
Signature of Patient/Legal Representative Date

_____ _____
Print name of the Patient/Legal Representative Relationship to Patient

_____ _____
Witness Witness

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