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

University Health

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 _____

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

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 informationthat has already be 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 ofsignature, 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**

TO BE PLACED IN MEDICAL RECORD