MEDICAL WEST
an affiliate of the UAB HEALTH SYSTEM

AUTHORIZATION FOR USE OR DISCLOSURE OF PATIENT INFORMATION

MEDICAL WEST
Health Information Management Department
995 9th Ave. SW BESSEMER, AL 35022
205-481-7166 phone 205-481-7559 fax

Date: _____

I hereby authorize the use or disclosure of my individually identifiable protected health information ("PHI") as described below. I understand that this authorization is voluntary. I understand that if the person or entity that receives the information is not a healthcare provider or health plan, the information disclosed may be redisclosed and no longer be protected by federal privacy regulations. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements. This Authorization includes any information relating to:

_____ drug and/or alcohol abuse/treatment

_____ communications with psychiatrists/psychologists

_____ sexually transmitted diseases & HIV

_____ Other_____

Patient name:_____ _____

Date of birth:_____

Patient Social Security #:_____

Phone: _____

Person/organization providing the information

_____

Person/organization receiving the information

_____

Mail To - Address: _____

City, State, Zip: _____

INFORMATION TO BE DISCLOSED:

____ History & Physical
____ Discharge Summary
____ Operative Report
____ Progress Notes
____ Abstract of Record
____ Other:_____
_____

____ Consult Report
____ ER Record
____ Lab
____ X-Ray/Scans
____ Entire Record

DATE(S) OR EVENT TO BE DISCLOSED:

_____

PURPOSE OF DISCLOSURE;

_____ Attorney
_____ Disability
_____ Other:_____

THE PATIENT OR THE PATIENT'S REPRESENTATIVE MUST READ AND INITIAL THE FOLLOWING STATEMENTS:

Initials:_____ I understand that I may revoke this Authorization at any time by notifying the MW Privacy Officer in writing.

Initials: _____ I understand that MW may not condition the provision of treatment or payment on signing this Authorization.

Initials: _____ I understand that this authorization will automatically expire in sixty (60) days

Signature of Patient/Representative: _____ Date: _____

Signature of Nurse if patient not medically capable:_____Date:_____

Printed Name of Patient's Representative: _____

Relationship to the Patient: _____

Witness: _____ Date: _____