UAB MEDICINE

Authorization for Use or Disclosure of Patient Information Hospital Records

I hereby authorize the use or disclosure of my protected health information ("PHI") as described below. This request includes any information relating to drug, alcohol use/treatment, communications with psychiatrists or psychologists, and records pertaining to sexually transmitted diseases, if they are a part of my medical record. I understand that this Authorization is voluntary. Once this information has been disclosed, it may be subject to re-disclosure and no longer be protected by federal regulations.

Patient Information (please print):

Patient Name: _____ Patient Birthdate: _____ /_____ /_____

Patient Street/Mailing Address: _____

City, State, and Zip: _____ Patient Phone: _____

UAB St. Vincent's should provide records to ☐ me for my personal use or to ☐ the party indicated below:

Name of person/organization receiving my information: _____

Street address: _____ City: _____ State: ____ Zip: _____

Select the Location(s) to release the information:

☐ UAB St. Vincent's Birmingham
☐ UAB St. Vincent's Blount
☐ UAB St. Vincent's Chilton
☐ UAB St. Vincent's East including the Free-Standing Emergency Department
☐ UAB Medicine St. Vincent's One Nineteen (Day Surgery and Cardiac Rehab)
☐ UAB St. Vincent's St. Clair

Are you requesting psychiatric or substance use records to be included in the release? ☐ Yes ☐ No

Date range for records: From _____ to _____ OR specific date: _____

(If no date is listed, records for the past 12 months will be provided.)

Select the record that best meets your need for this Authorization:

☐ Key Clinical Notes: discharge summary, operative reports, labs and radiology reports, Emergency Department provider documentation

☐ Entire Medical Record (excluding billing records, Fetal Monitoring, and Radiology images.) However, if your request is specifically for any of the following only, please check the appropriate box (es):

☐ Operative/Procedure Report(s) ☐ Emergency Department Record
☐ Discharge Summary ☐ Billing Records ☐ Medication List
☐ Fetal Monitoring Strips ☐ Lab Reports ☐ Radiology Reports
☐ Radiology Images: Please specify images needed: _____
☐ Other specific record needed :_____

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Records Delivery (select one)

☐ **Paper**:
- ☐ Mailed to address on this Authorization
- ☐ Pick up by _____

☐ **Electronic:**
- ☐ Faxed to number: _____
- ☐ CD (mailed only to address on this Authorization)
- ☐ Email to address: _____

NOTICE: If I request records in electronic form, I understand that the records will be encrypted to help protect my privacy and the security of my health records and that I will be furnished with the information on how to access those encrypted records. UAB St. Vincent's is not responsible for the privacy and security of the electronic records on the CD or in an email once they are received by the intended recipient.

The patient or the patient's representative must read and acknowledge the following statements by initialing each blank:

_____ I understand that I may revoke this Authorization at any time by notifying the entity privacy coordinator in writing, but if I do, it will not be effective for disclosures made prior to my revocation in reliance on the Authorization.

_____ I understand that UAB St. Vincent's may not condition the provision of treatment, payment, and enrollment in a health plan, or eligibility for benefits on signing this Authorization, except under the following circumstances:

- Participation in research projects can be conditioned on my signing an Authorization to use and disclose PHI in the research.
- Initial enrollment in health plans can be conditioned on signing an Authorization for the health plan to review PHI to make eligibility determinations.
- Furnishing healthcare services to me at the request of a third party can be conditioned on me signing an Authorization for disclosure of the PHI to the third party requesting the treatment.

This Authorization will expire on: _____.
If I fail to specify an expiration date or event, this Authorization will expire six months from the date on which it was signed.

Signature of patient or personal representative: _____

Printed name of patient: _____

Printed name of personal representative: _____

Relationship to the patient: _____

Date: _____

Return Completed Form:
Visit our website for the mailing address: https://uabstvincents.org/billing/medical-records-request/