Medical Record Number: _____

Patient Name: _____

Authorization For Use or Disclosure of Protected Health Information/Access to Protected Health Information

PATIENT INFORMATION	NAME: _____ Date of Birth: _____ Address: _____ Phone: _____ City: _____ State: _____ Zip: _____
Clinic/Hospital/ Health Care Provider (Please indicate the specific physician, hospital, clinic, etc. who has the information you want released.)	NAME: _____ Attn: _____ Phone: _____ Fax: _____ Address: _____ City: _____ State: _____ Zip: _____
Receiving Party (Where do you want the information sent?)	NAME: _____ Attn: _____ Phone: _____ Fax: _____ Address: _____ City: _____ State: _____ Zip: _____
Health Information to be Used/Disclosed (What health information do you want sent?) Check (✓) all that apply	___Discharge Summary ___Inpatient Records ___Emergency Room Records ___Complications and Procedures ___Consultation Reports ___Abstracts ___Outpatient Clinic Notes ___Reports of Tests & X-rays ___Final Diagnosis ___Outpatient Records ___History & Physical Records ___Physical Therapy Notes ___Immunization (shot) record ___Other*:_____ (*I understand a fee may be charged for copies of my medical record.*)
What are the dates of service and how do you want the information released?	Dates of treatment to be released: _____ I request the form of the information to be ☐ Paper ☐ Electronic Specify preference for Electronic release: _____

Medical Record Number: _____

Patient Name: _____

Authorization For Use or Disclosure of Protected Health Information/Access to Protected Health Information

Reason or purpose for use and/or disclosure of the information: (Why is it needed?)	❑ Personal use or review ❑ Transfer of Care ❑ Continuity of Care ❑ Social Security ❑ Insurance Purposes ❑ Litigation/Legal Other: _____

***If authorization is for marketing, indicate if Trinity Health System will receive compensation in exchange for the use and/or disclosure of the PHI. ☐ Yes ☐ No**

Prohibition on Conditioning of Authorization: Trinity Health System will not condition treatment on your signing this authorization, unless:

- You are receiving research-related treatment; or
- The only reason the facility is providing you with health care is to make a report to a third party, such as your employer (e.g., fitness to return to work) or school (e.g., P.E. physical).

Re-disclosure: I understand that the information used and/or disclosed according to this authorization may no longer be protected by federal privacy law (also known as HIPAA) and the recipient of your health information may potentially re-disclose it. However, under the Federal Substance Abuse Confidentiality Requirements, 42 CFR Part 2, the recipient may be prohibited from disclosing identifiable substance abuse information.

Expiration: This authorization will expire in 90 days or once purpose stated above is served.

Revocation: I understand that I may revoke this authorization at any time by notifying Trinity Health System in writing by sending a letter to **Trinity Health System, Medical Records Department, 4000 Johnson Road, Steubenville, OH 43952** or completing the Revocation of Authorization form. I understand that if I revoke this authorization, it will not affect any actions that Trinity Health System took before it received my revocation letter. For example, Trinity Health System cannot rescind disclosures it has already made, and may use my health information as necessary to bill and collect for services rendered.

This Authorization is binding: The statements made in this authorization are binding, controlling and I understand that they take precedence over statements made in the Trinity Health System's Notice of Privacy Practices.

_____

SIGNATURE OF INDIVIDUAL OR PERSONAL REPRESENTATIVE DATE

_____

Printed name of individual's personal representative, if applicable.

_____

Rationale for serving as personal representative to the individual (*e.g. parent, legal guardian*).

Medical Record Number: _____

Patient Name: _____

Authorization For Use or Disclosure of Protected Health Information/Access to Protected Health Information

FOR INTERNAL PURPOSES ONLY

When Trinity Health System is requesting an authorization to use health information for its own use, the following provision must be completed:

Staff Personnel:

Received by: _____ Date: _____

Was a signed copy provided to the individual? ___YES ___NO

Access approved? ___YES ___NO