HIPAA Authorization and Disclosure of Protected Health Information

Section 45 CFR §164.508 of the HIPAA regulations state, a covered entity (DCH Health System) must obtain the patient's written authorization for any use or disclosure of protected health information (PHI) that is not for treatment, payment, or healthcare operations.

Patient Information:

Name: _____ Date of Birth: _____

Address: _____ Last 4 digits of SSN: _____

_____ Admission Date: _____

Are you completing this form for a Minor? Yes____ No____ If **yes**, please complete the information below.

Requestor Name:_____ Relationship to Patient:_____

Please initial the statements below you are in agreement with.

Description of Patient's PHI to be Disclosed:

_____ All health information **INCLUDING** the following (check all that apply):

____ Canceling, changing or making patient's appointments
____ Pick up Patient's RX with proper ID
____ Pick up patient's forms (example: appointment schedule)
____ Check on patient's status during appointments or treatment

Treating Facility:

_____ Lewis and Faye Manderson Cancer Center

Person(s) Authorized to Disclose my PHI:

DCH Health System
Lewis and Faye Manderson Cancer Center
809 University Blvd. East
Tuscaloosa, AL 35401

By signing this authorization below, I hereby authorize Lewis and Faye Manderson Cancer Center and its business associate(s) to disclose my protected health information as authorized below.

Person(s) Authorized to Receive my PHI:

Name:_____
Address:_____
Telephone:_____
Relationship to Patient:_____
DOB of Authorized Individual:_____

Person(s) Authorized to Receive my PHI:

Name:_____
Address:_____
Telephone:_____
Relationship to Patient:_____
DOB of Authorized Individual:_____

Purpose of this Disclosure of PHI:

_____ At the patient's request

_____ Other (please specify) _____

Date of Expiration:

_____ Twelve (12) months from the date of this authorization

_____ Until my treatment or event is complete at Lewis and Faye Manderson Cancer Center not to exceed a 12 month period

_____Specific Timeframe_____

Right to Revoke Authorization:
I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing to the Medical Records Department. I understand that revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

Signature:
I understand the authorization to disclose my protected health information is voluntary. I need not sign this authorization in order to receive treatment. I understand Lewis and Faye Manderson Cancer Center may re-disclose my PHI in a manner that makes it no longer protected. A copy of my signed authorization may be provided to me for my records.

Print Name: _____

Signature: _____

Date Signed: _____

Personal Representative Signature: (if necessary)

If the patient's personal representative is signing the authorization, **he or she must provide valid identification and a copy of the Power of Attorney.**

Print Name: _____

Signature: _____

Date Signed: _____

DCH Health System®

FOR INTERNAL USE ONLY

Name of Employee:_____ Date Identification Verified:_____

Identification of Patient or Patient's Personal Representative:

___Driver's License ___Other Photo ID (i.e. Passport)

___SSN Card ___Power of Attorney

___Work Photo Badge ___Other (please specify) _____

Comments (if necessary):_____
_____
_____
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