AUTHORIZATION TO USE AND/OR DISCLOSE HEALTH INFORMATION

LOGAN UNIVERSITY HEALTH CENTERS

FOR OFFICE USE ONLY
Revocation
Date Revoked:_____
Initials of Privacy Official_____
Medical Record No._____

Please Print
Patient Name:_____ _____/_____/_____
First M.I. Last Date of Birth

Address on File: _____
City State Zip Code

Please Circle Location: Chesterfield St. Peters Paraquad

I authorize this Health Center to use or disclose my health information as described below.

1. **Type of information:** The type of information to be used or disclosed is as follows (check the appropriate spaces and include other information where indicated):

_____The entire Medical Record (all information)	_____Minimum Data Set
_____Activity documentation	_____Nursing documentation/progress notes
_____Assessments, flow sheets	_____Nutritional services documentation
_____Business Office File	_____Physician and professional consult progress notes
_____Care Plan	_____Physician's orders
_____Diagnostic reports (lab, x-ray, etc.)	_____Rehabilitative and restorative therapy documentation
_____History and physical, other hospital records	_____Social Services documentation
_____Medication and treatment records	
_____Other: (Describe below)	

_____

_____

_____

2. **Recipient of information** - The information identified above may be used by, or disclosed to, the following individual(s) or organization(s):

Name: _____ Name: _____

Address: _____ Address: _____

_____ _____

Name: _____ Name: _____

Address: _____ Address: _____

_____ _____

3. **Purpose of use/disclosure -** This information described on the previous page will be used for the following purpose(s):

    ____Initiated at the request of the patient.

    ____My personal records

    ____Sharing with other health care providers as needed

    ____Other (please describe):_____

Authorization Statements/Signatures:

4. I understand that once the above information is disclosed, it may be re-disclosed by the recipient and the HIPAA Privacy Rule may no longer protect the information.

5. **For marketing disclosures only:** ***(Check if applicable)*** _____I understand that the Health Center will receive compensation related to the use or disclosure of the requested information.

6. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to a licensed Health Center staff member. I understand that the revocation will not apply to information that has already been released in response to this authorization.

7. **Required:** Unless I specify differently, this authorization will expire (insert date or event):

    _____

8. I understand that the Health Center will not condition the provision of treatment or payment on the provision of this authorization.

_____ _____

Signature of Patient or Personal Representative Date

_____

Print Name

_____

Personal Representative's Title (e.g., Guardian, Executor of Estate, Health Care Power of Attorney)