

BAHC Request for Access to/Authorization for Use and Disclosure of Protected Health Information

PATIENT NAME: _____
Last First MI Maiden or other name

DATE OF BIRTH: ____ -- ____ -- ____ FORMER NAME: _____ MEDICAL RECORD #: _____
MO DAY YEAR

ADDRESS: _____ CITY: _____ STATE: ____ ZIP: _____

I hereby authorize BAHC to disclose/obtain my protected health information as indicated below to:

Mail to: Hold for pick up by: Fax to: Obtain From:

NAME: _____ RELATIONSHIP: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

FAX NUMBER: _____ PHONE NUMBER: _____

INFORMATION TO BE RELEASED:

- Discharge Summary
- History and Physical
- Progress Notes
- Lab Reports
- X-ray Reports
- Medication Record
- Detailed Bill
- Other (specify content and dates): _____

Dates: _____

<p>I specifically authorize the release of information related to:</p> <p><input type="checkbox"/> Substance abuse (including alcohol and drug)</p> <p><input type="checkbox"/> Mental health or behavioral health</p> <p><input type="checkbox"/> HIV related information</p> <p>_____ Signature of patient or personal representative/ Date</p>

PURPOSE OF DISCLOSURE:

- Changing physicians Consultation Insurance/Workers' Compensation School Research At individual request
- Legal (specify) _____
- Other (specify) _____
- For personal access (specify) Copy Inspection Summary

ACKNOWLEDGEMENT OF UNDERSTANDING:

Initial each line

- I understand the expiration date of this authorization is _____ (six months from signature)
- I understand that I may revoke this authorization at any time by notifying the providing organization in writing, and it will be effective on the date notified, except to the extent action has already been taken in reliance upon it.
- I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by Federal privacy regulations.
- By authorizing this use or disclosure of information, there will be no conditions placed on my health care or payment for health care
- I understand that if I am being requested to authorize a use or disclosure that I will get a copy of this form after I sign it upon request.
- I understand my request will be acted upon within 30 days. If I am not provided access or information cannot be supplied, I understand I will be notified and have the right to request review of any denial of access other than those made in accordance with applicable law.
- I understand that I may be required to pay the cost of preparing and mailing copies, except for the purpose of treatment or payment.

Patient/Legal Representative Signature: _____ Date: _____

Relationship: _____

Date Completed: _____ Initials: _____