AUTHORIZATION TO **REQUEST/RECEIVE** PATIENT PROTECTED HEALTH INFORMATION

Patient Name: ____
Last First Middle Initial

Address: ____City/State: _______________ Zip: _________

Phone Number: __________________________ Date of Birth: ______________UMA Patient ID: ______________

I HEREBY AUTHORIZE UNIVERSITY MEDICAL ASSOCIATES, INC. ("UMA") TO **REQUEST AND RECEIVE** MY PROTECTED HEALTH INFORMATION OR THE PROTECTED HEALTH INFORMATION OF A MINOR FOR WHICH I HAVE LEGAL AUTHORITY TO MAKE SUCH A REQUEST FROM THE FOLLOWING:

Name of organization/person: ____

Address: ____

City: ____________________ State: _________ ZIP: _______ Phone: _______________ Fax: ________________

REQUESTED PHI SHOULD BE MAILED OR FAXED TO: **(TO BE COMPLETED BY UMA STAFF)**
University Medical Associates, Inc.
____
(Department Name and Address)
Athens, Ohio 45701
Fax #: (740) _________________________________
(Department Fax Number)

I HEREBY AUTHORIZE UMA TO **REQUEST AND RECEIVE** THE FOLLOWING PROTECTED HEALTH INFORMATION FOR THE DATE RANGE OF __________ TO ____________:
CHECK ALL THAT APPLY

Check here if you would like your complete health record requested, which includes all categories listed below: _______

_______Immunization Records _______ Itemized Bills and Billing Records _______Complete Health Record *(includes all categories listed)*

_______Radiology Reports _______ Consultations _______ADD/ADHD Records _______Pap & STI Results _______ Provider notes

_______ Prescription Records _______ Laboratory Results _______GYN Records _______Other:___________________________

I UNDERSTAND THAT THE INFORMATION IN MY HEALTH RECORD MAY INCLUDE INFORMATION RELATING TO SEXUALLY TRANSMITTED DISEASE, ACQUIRED IMMUNODEFICIENCY SYNDROME (AIDS) OR HUMAN IMMUNODEFICIENCY VIRUS (HIV). IT MAY ALSO INCLUDE INFORMATION ABOUT BEHAVIORAL OR MENTAL HEALTH SERVICES AND TREATMENT FOR ALCOHOL AND DRUG ABUSE.

IF YOU **DO NOT** WISH TO AUTHORIZE THE RELEASE OF RECORDS RELATING TO ALCOHOL/DRUG ABUSE, HIV/AIDS, OR MENTAL HEALTH/DISABILITIES PLEASE INITIAL HERE: ____________

MY SIGNATURE BELOW INDICATES MY UNDERSTANDING OF THE FOLLOWING:

- I have the right to revoke this authorization at any time and that authorizing this disclosure of health information is voluntary and I can refuse to sign this authorization.
- I do not need to sign this form to receive treatment.
- I may revoke this authorization and must do so in writing.
- Unless noted otherwise, this authorization is valid for 90 days.
- Any disclosure of information carries with it the potential for an un-authorized re-disclosure and the information may not be protected by federal confidentiality rules.
- If I have questions about the disclosure of health information I may contact the UMA Privacy Officer, 355 Parks Hall, Athens, Ohio, 45701.

_____________________________________ _________________________ __________________

Signature of Patient or Legal Representative **Legal Relationship** ***(If not the patient)*** **Date**