AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Section A: Must be completed for all authorizations

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that information released according to this authorization may lose the protections of federal privacy regulations due to re-disclosure by the recipient.

***Patient Name: _____ *DOS: _____ Patient ID: _____**

***Address: _____ *Phone: _____ *DOB: _____**

Previous Name/Contact (if applicable):_____ *Required fields

Persons/organizations providing PHI: **Persons/organizations receiving PHI:**

_____ _____

_____ _____

Preferred Media type (Electronic/Paper): _____

Specific description of information (including date(s)): _____

Purpose of the use or disclosure_____

_____

Section B: Must be completed by SCAH for all authorizations

SCAH must complete the following:

1. Will SCAH receive payment, directly or indirectly, in exchange for using or disclosing the health information described above.

   Yes_____No_____

Section C: Must be completed by the patient or patient representative for all authorizations

The patient or the patient's representative must read and initial the following statements:

1. I understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment, receive payment, or eligibility for benefits unless allowed by law, including research-related treatment which may be conditioned upon this authorization.

   Initials: _____

2. I understand that this authorization will expire on _ _/_ _/_ _ _ _ (DD/MM/YR) Initials: _____
   (Research-related authorizations may have "none" or "end of study" in lieu of a specific date.)

3. I understand that I may revoke this authorization at any time by notifying the providing organization in writing, but if I do, it will not have any effect on any actions taken before receiving the revocation.

   Initials: _____

_____ _____

Signature of patient or patient's representative **Date**

(Form MUST be completed before signing)

Printed name of patient's representative_____

Relationship to the patient: _____

SCAH will not condition treatment, payment, enrollment in the health plan, or eligibility for benefits on the individual's providing authorization for the requested use or disclosure, except as provided in Policy *CMP_02_119: Conditioning Services on the Provision of an Authorization to Disclose Protected Health Information.*

Updated 8/23/2023