

Patient Authorization to Use or Disclose Protected Health Information

I, \_\_\_\_\_, understand St. Barbara's surgery Center is authorized by me to use or disclose my protected health information for a purpose other than treatment, payment, or health care operations. I have read this authorization and understand what information will be used or disclosed, who may use and disclose the information, and the recipient(s) of that information. I specifically authorize any current employee or owner of St. Barbara's Surgery Center, or any other individual listed below to disclose my protected health information as described on this form to the recipients listed below. I understand that when the information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected health information. I further understand that I retain the right to revoke this authorization, if done so according to the steps set forth below.

Description of the information to be used to disclosed (*Check all that apply*):

The patient's entire medical record  
(NOTE: This requires an explanation why the entire record may be disclosed).

The patient's demographic information (*Check all that apply*):  
 Name       Address       State/Zip Code only       Telephone  
 Age       Gender       Race       Other: \_\_\_\_\_

Medical Data/Information as related to:  
 Specific condition(s): \_\_\_\_\_  
 Specific professional service(s): \_\_\_\_\_  
 Specific medication(s): \_\_\_\_\_  
 Other: \_\_\_\_\_

Other: \_\_\_\_\_  
\_\_\_\_\_

Name(s) or class of person(s) other than current employees or owner(s) authorized by this form to use and disclose the patient's protected health information:

\_\_\_\_\_

Name(s) or class of person(s) authorized by this form who may use and disclose the patient's protected health information:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Purpose(s) of the information:

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(*Check if applicable*) This authorization is to be used for our own use, and St. Barbara's Surgery Center will not condition treatment or payment on this authorization. Moreover, the patient has a right to inspect or copy the information to be used to disclosed and may refuse to sign this authorization.

(*Check if applicable*) The patient understands that St. Barbara's Surgery Center may receive financial gain as a result of disclosing this information due to \_\_\_\_\_.

(*Check if applicable*) This authorization permits St. Barbara's Surgery Center to send the protected health information ONLY to this address or fax number:

\_\_\_\_\_  
Any other address or fax number is not permitted by this authorization.

The patient had a right to revoke this authorization in writing, except to the extent that action has been taken in reliance on this authorization or, if applicable, during a contestability period. In order for the revocation of this authorization to be effective, St. Barbara's Surgery Center must receive the revocation in writing. The revocation must include:

- The patient's name, address, and patient number, if applicable,
- The effective date of this authorization, and the recipients of the protected health information according to this authorization,
- The patient's desire to revoke this authorization, and
- The Date of the revocation, and the patient's signature.

St. Barbara's Surgery Center will accept written revocations of this authorization via:

Certified U.S. mail

Facsimile at this number: 239-481-7898

ALL revocations must be sent to St. Barbara's surgery Center to the attention of the Privacy Officer and are not effective until received by the Privacy Officer.

This authorization shall expire on \_\_\_\_\_. After this date, St. Barbara's Surgery Center can no longer use or disclose the patient's protected health information without first obtaining a new authorization form.

I fully understand and accept the terms of this authorization.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

FOR OFFICE USE ONLY

Authorization added to the patient's medical record on \_\_\_\_\_.

Authorization verified by \_\_\_\_\_ on \_\_\_\_\_.

### **In-Person Request for Protected Health Information**

Before St. Barbara's Surgery Center can complete your request for protected health information, we must first verify and document your identity, the information you would like to use or disclose, and your purpose(s) in requesting this information. You understand that if you request protected health information from a patient without his or her authorization, we may refuse to provide you access to this information.

Please fill out the information below. Be as accurate and specific as possible.

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Date: \_\_\_\_\_

Time: \_\_\_\_\_

*Person Requesting Information*

Name: \_\_\_\_\_

Business: \_\_\_\_\_

Address: \_\_\_\_\_

Home Tel: \_\_\_\_\_

Work Tel: \_\_\_\_\_

*Relationship to patient (check one):*

- Spouse     Parent     Child     Grandparent     Grandchild  
 Aunt or Uncle     Attorney (or representative) of patient     Legal Guardian  
 Other: \_\_\_\_\_

*Information Requested:*

Name/Class of Patient(s): \_\_\_\_\_

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I am requesting the following protected health information:

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The purpose(s) of my obtaining this information is (*check all that apply*):

- Treatment of the patient     Payment     Health care operations     Other

Please explain: \_\_\_\_\_

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**Request for Correction/Amendment of Health Information**

You have the right to request an amendment to your protected health information. If you would like to request an amendment to your protected health information, please complete the form below and hand it to the Privacy Officer.

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Patient Name: \_\_\_\_\_ Birth date: \_\_\_\_\_

Patient Number: \_\_\_\_\_

Patient Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Date of amendment request: \_\_\_\_\_

Please explain how the entry is incorrect or incomplete. What should the entry say to be more accurate or complete?

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Would you like this amendment sent to anyone to whom we may have disclosed the information in the past? If so, please specify the name and address of the organization(s) or individual(s).

Name/Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Name/Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I understand that by listing the name(s) and address(es) of other organizations on this Amendment form, I am asking St. Barbara's Surgery Center to disclose the requested amendment to these organizations. I therefore, give specific permission to St. Barbara's Surgery Center to disclose the amendment to these organizations, and I understand that St. Barbara's Surgery Center will take reasonable steps to send the requested amendment to these organizations.

In addition, I understand St. Barbara's Surgery Center may be required to send this amendment to Business Associates or other organizations that St. Barbara's Surgery

Center identifies as needing the amendment. I therefore, give specific permission to St. Barbara's Surgery Center to send the requested amendment to these organizations identified by St. Barbara's Surgery Center as needing the amendment.

I further understand that it is my responsibility to identify any originator(s) of my protected health information who may be not longer available to act on this amendment request, and present to St. Barbara's surgery Center evidence that I have attempted to contact the originator(s). If I cannot present evidence of my attempts, St. Barbara's Surgery Center may deny the amendment request.

By signing below, I fully acknowledge and agree to the above terms.

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Signature of Patient

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Date