HEALTH CENTER

AUTHORIZATION FOR USE & DISCLOSURE OF HEALTH INFORMATION

Name of Individual/Previous Names	Birth Date	( ) Phone number
Street Address	City State Zip	

AUTHORIZES:

Individual(s)/Agency/Organization receiving information

Street Address

City State Zip

DISCLOSURE OF PROTECTED INFORMATION TO:

Dr. Royden Christensen
BYU-H #1728, Health Center
55-220 Kulanui Street, Bldg. 5
Laie, HI 96762
Fax: (808) 675-3506

INFORMATION TO BE USED &/OR DISCLOSED:
The following is a specific description of the health information to be used and/or disclosed (e.g., progress notes, labs, claims history):

_____

_____

In compliance with State and Federal statutes which require permission to release otherwise privileged information, please release records pertaining to:

[Check all that apply] ❒Mental Health ❒Development Disabilities ❒Alcohol &/or Drug Abuse ❒HIV test results

❒Other (Specify): _____

For the following dates(s): From: _____ To: _____

PURPOSE FOR NEED OF DISCLOSURE: (Check applicable categories)

❒Further medical care ❒Coordinating Care for Dependent/Spouse ❒Insurance Eligibility/Benefits ❒Claims Resolution

❒Other (Specify): _____

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:

RIGHT TO RECEIVE COPY OF THIS AUTHORIZATION – I understand that if I sign this authorization, I will be provided with a copy of this authorization if requested.

RIGHT TO REFUSE TO SIGN THIS AUTHORIZATION – I understand that I am under no obligation to sign this form and that the BYU-H Health Center may not condition treatment, payments, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization except regarding: (a) research-related treatment, (b) health plan enrollment or eligibility, (c) the provision of health care that is solely for the purpose of creating PHI for disclosure to a third party.

RIGHT TO WITHDRAW THIS AUTHORIZATION – I understand that I have the right to withdraw this authorization at any time by providing a written statement of withdrawal to the BYU-H Health Center. I am aware that my withdrawal will not be effective until received by the BYU-H Health Center and will not be effective regarding the uses and/or disclosures of my health information that the BYU-H Health Center has made prior to receipt of my withdrawal statement. I understand if the authorization was obtained as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy of the policy itself.

MARKETING – I understand if the BYU-H Health Center uses this authorization for marketing activities, I will be informed if they receive any direct or indirect payment in connection with the use of disclosure of my information.

RIGHT TO INSPECT OR COPY THE HEALTH INFORMATION TO BE USED OR DISCLOSED – I understand that I have the right to inspect or copy (may be provided at a reasonable fee) the health information I have authorized to be used or disclosed by this authorization form. I may arrange to inspect my health information or obtain copies of my health information by contacting the Director of the BYU-H Health Center.

HIV TEST RESULTS – I understand my HIV test results may be released without authorization to persons/organizations that have access under State law and a list of those persons/organizations is available upon request.

RE-DISCLOSURE NOTICE: I understand that information used or disclosed based on this authorization may be subject to re-disclosure and no longer protected by Federal privacy standards.

EXPIRATION DATE: This authorization is good until (indicate date or event) _____. By signing this authorization, I am confirming that it accurately reflects my wishes.

SIGNATURE OF PATIENT/LEGAL REP:

_____ _____

(If signed by other than individual, state relationship next to your signature) Date

This authorization is prepared in conjunction with the Authorization/Informed Consent for use and Disclosure of Health Care Information Grid that enumerates requirements of State and Federal privacy laws.