Marshall Health
A provider-based facility of Cabell Huntington Hospital

Authorization to Use/Disclose Health Information

I authorize University Physicians & Surgeons, Inc. to use and disclose health information of the following named individual to the extent stated in this authorization.

Individual's name: _____ DOB: _____ SSN: ___-___-_____

1. Check one: ❑ Send records to: ❑ Receive records from: ❑ Disclose information to:

Name/Organization: _____ Daytime phone: ___-___-_____

Address: _____ City, state and zip: _____

2. Purpose of Use/Disclosure (check one):

❑ Further medical treatment ❑ Personal use ❑ At the request of the patient ❑ Legal use
❑ Other (specify):_____

3. Format Requested (check one): ❑ Paper ❑ Electronic ❑ _____

4. Specific information to be used/disclosed (include dates of service if possible):

_____

_____

I authorize the use and disclosure of health information as specified above. I understand that authorizing the use and disclosure of this medical information is voluntary and treatment, payment and other benefits may not be conditioned on the execution of this authorization. I understand I may inspect or copy the information to be used or disclosed, as provided in 45 CFR 164.524. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal privacy standards. If I have questions about disclosure of my medical information, I can contact the appropriate department or the Privacy Officer.

I understand that my medical information 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.

I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing and present my written revocation to the appropriate department. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____. If I fail to specify an expiration date, event or condition, this authorization will expire in one year.

Individual/Legal representative signature: _____ Date: _____

Relationship, if not individual: _____

Witness signature: _____ Date: _____

Name of witness (please print): _____

REV 10-20

DO NOT WRITE IN THIS BOX

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PATIENT INFORMATION LABEL