Completion Date:

Attachment 46
Authorization for 3rd Party Disclosures

UHealth UNIVERSITY OF MIAMI HEALTH SYSTEM | UNIVERSITY OF MIAMI MILLER SCHOOL of MEDICINE

I authorize the use or disclosure of health information about me as described below.

1. Person(s) or class of persons authorized to use or disclose the information **(e.g., UHealth medical records, physician)**:

_____

2. Person(s) or class of persons authorized to receive the information **(e.g., name & relationship: family, attorney, employer, etc.)**:

_____

If you would like your records to be sent to a third party, please provide an address or fax where you would like us to send the information. Please attach additional pages if more than one third party.

Name: _____ Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

3. Description of information that may be used or disclosed **(e.g., all information related to a specific type of treatment)**:

_____

_____

The following must be separately initialed by you if applicable to your authorization:

____ HIV/AIDS STATUS – HIV related information, which includes any information indicating that I have had an HIV-related test, or HIV infection, HIV-related illness or AIDS, or any information which would indicate that I have been potentially exposed to HIV.

____ Sexually transmitted diseases

____ Sexual assault information

____ Mental health treatment records governed under state law (including mental health records relating to involuntary or voluntary mental health treatment). *Mental health records may include substance abuse information.*

____ Substance abuse (drug and alcohol) treatment records. *Substance abuse information may be part of mental health records.*

4. The information will be used or disclosed for the following purposes **(Note: if a patient initiates the request, the statement "at the request of the patient" is sufficient)**:

_____

5. *[If applicable]* The disclosure of my information for marketing purposes is expected to result in a direct or indirect financial benefit to _____ *[insert the name of the disclosing covered entity]*.

6. This authorization expires _____ *[insert a date or describe an event or activity related to the patient or purpose of the authorization]*. If not completed, this authorization will expire one year from date signed.

I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be redisclosed and no longer protected by these regulations. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment, enrollment, or my eligibility for benefits. I understand that I may revoke this authorization at any time by sending a written request to the University of Miami Office of HIPAA Privacy and Security, PO Box 019132 (M-879) Miami, FL. 33101, except to the extent that action has been taken in reliance on this authorization.

_____ _____

Signature of Patient or Representative | Date

_____ _____

Patient Name | Patient Address

_____ _____ _____

Patient Contact Phone Number | Last 4 Digits of SSN | Date of Birth

_____ _____

Name of Personal Representative (if applicable) | Relationship to Patient

University of Miami – Office of HIPAA Privacy & Security
PO Box 019132 (M-879) **hipaaprivacy@med.miami.edu**
Miami, FL 33101 **305-243-5000 1-866-366-4874**

AUTHORIZATION FOR 3RD PARTY DISCLOSURES

Form D3900052E

Revised 6/03/14

NAME: _____

MRN: _____

LAST 4 DIGITS OF SSN: _____

DOB: ____/____/____

DATE: _____ TIME: _____