UCBC | UHA
UNIVERSITY CANCER & BLOOD CENTER
UNIVERSITY HEALTH ALLIANCE

# AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

The undersigned authorizes University Cancer & Blood Center | University Health Alliance (main office located at 3320 Old Jefferson Road, Bldg. 800, Athens, GA 30607) to release my health information as noted below.

## PATIENT INFORMATION

| | | |
|---|---|---|
| Full Name: | DOB: | SSN: |
| Address: | City/State/Zip: | |
| Preferred Phone: | Email: | |

## PERSON OR COMPANY WHO WILL RECEIVE INFORMATION

❑ Provide a copy of my PHI (Protected Health Information) to me

| | |
|---|---|
| ❑ Send a copy of my PHI to: | Phone: |
| Address/City/State/Zip: | |

## INFORMATION TO BE RELEASED

❑ Abstract/Summary (Office Notes, Lab, Pathology, Radiology Reports, Operative/Procedure Notes)

**OR** Select Specific Individual Reports below

❑ Office Notes ❑ Operative/Procedure Note ❑ Lab/Pathology Reports ❑ Radiology Reports

❑ Other (please specify): _____

❑ Radiology Images
*We only provide radiology images of scans performed at UCBC

Billing Records
❑ Itemized Billing
❑ Cancer Policy Report

**Purpose of Request:** ❑ Personal ❑ Continuation of Care/Transfer of Care ❑ Legal ❑ Insurance ❑ Other:

**Date(s) of Service from:** _____ **to** _____ (If not specified, one (1) year of records will be provided.)

## METHOD AND FORMAT OF DELIVERY

**Electronic Delivery**

❑ Fax (where permitted): _____

❑ Encrypted email: _____

*While reasonable safeguards are in place, electronic transmission may present risks to the privacy and security of your information. By selecting email delivery, you acknowledge and accept these risks.

**Paper Delivery**

❑ Mail to address above

❑ Pickup at Athens location **ONLY**

*Records will be held for thirty (30) days after notification for pickup. Unclaimed records will be securely disposed of.

## AUTHORIZATION

By initialing here _____, I specifically authorize the release of the following sensitive or privileged information such as the diagnosis or treatment for alcohol and/or drug abuse; psychiatric or mental illness; sexually transmitted diseases (STDs), as well as AIDS or HIV information.

I understand I may revoke this authorization at any time in writing to UCBC's Privacy Officer, except to the extent that action has already been taken or as otherwise permitted by law, including disclosures to my insurer for claim review. Unless revoked earlier, this authorization will expire on _____ or, if not specified, in 90 days from the date of signature. I understand signing is voluntary, and my treatment will not be affected if I refuse. I understand information disclosed may be re-disclosed by the recipient and may no longer be protected by federal privacy laws.

X _____ _____ _____

Signature of Patient/Authorized Representative | Please Print Name | Date

Relationship to Patient: ❍ Patient (self) ❍ Parent (of a minor patient) ❍ Legal / Court-Appointed Guardian ❍ Healthcare Power of Attorney

**UCBC|UHA partner with Docfluent, a third-party service provider, to process medical record requests on our behalf in accordance with applicable privacy laws**