MEDTRUST LLC

UNIVERSAL PATIENT AUTHORIZATION FORM FOR LIMITED DISCLOSURE OF HEALTH INFORMATION

****PLEASE READ THE ENTIRE FORM BEFORE SIGNING BELOW****

Individual (name and information of person whose health information is being disclosed):

Name (First Middle Last):_____ Date of Birth (mm/dd/yyyy):_____

Address:_____ City:_____ State:_____ Zip: _____

You may use this form to allow limited access to your health information by certain persons for certain purposes.

By signing this form, I voluntarily authorize and give my permission and allow disclosure (including paper, oral and electronic interchange):

OF WHAT: (initial one)

_____ **ALL MY HEALTH INFORMATION including information about sensitive conditions (if any). Health information includes, but is not limited to, all records and other information regarding my health history, treatment, hospitalization, tests, and outpatient care, and also educational records that may contain information about my health. This includes my specific permission to release any and all of the following information:**

a) Drug, alcohol, or substance abuse
b) Psychological, psychiatric or other mental impairment(s) or developmental disabilities (excludes "psychotherapy notes" as defined in HIPAA at 45 CFR 164.501)
c) Birth control and family planning
d) Records which may indicate the presence of a communicable disease or noncommunicable disease; and tests for or records of HIV/AIDS or sexually transmitted diseases or tuberculosis
e) Genetic (inherited) diseases or tests
f) Copies of educational tests or evaluations, including Individualized Educational Programs, assessments, psychological and speech evaluations, immunizations, recorded health information (such as height, weight), and information about injuries or treatment.

_____ **ONLY THE INFORMATION INDICATED BELOW** (initial next to all that you want disclosed):

_____History and Physical _____Operation Reports _____Discharge Summary_____Radiology Reports & Images

_____Pathology Reports _____EKG Reports _____Progress Notes _____Consultation Reports

_____Lab Results _____Physician's Orders _____Drug, Alcohol or Substance Abuse Records

_____Family Planning Records _____Prenatal Records _____Infirmary Records

_____Mental Health Records (excluding "psychotherapy notes" as defined in HIPAA at 45 CFR 164.501)

_____Diagnostic Test Reports (specify type of test): _____

_____Other (please specify): _____

Note: Information created before or after the date of this form may be disclosed, unless you specify a date range of records here:

From (mm/dd/yyyy):_____ To (mm/dd/yyyy) :_____.

FROM WHOM: (choose one)

☐ **All information sources,** including but not limited to medical and clinical sources (hospitals, clinics, labs, pharmacies, physicians, psychologists, etc.) including mental health, correctional, addiction treatment, Veterans Affairs health care facilities, state registries and other state programs, all educational sources (schools, records administrators, counselors, etc.), social workers, rehabilitation counselors, insurance companies, health plans, health maintenance organizations, employers, pharmacy benefit managers, worker's compensation programs, state Medicaid, Medicare and any other governmental program.

☐ **Only the following specific sources of my health information**:

Person/Organization Name:_____ Phone: (_) _____

Address:_____ Fax: (_)_____

Person/Organization Name:_____ Phone: (_) _____

Address:_____ Fax: (___)_____

TO WHOM: (check one)

☐ Specific person(s) or organization(s) permitted to receive my information:

Person/Organization Name:_____ Phone: (_____)_____

Address:_____ Fax: (_____)_____

Person/Organization Name:_____ Phone: (_____)_____

Address:_____ Fax: (_____)_____

PURPOSE: (check all that apply)

- ☐ My medical treatment and related services
- ☐ To evaluate and improve patient safety and the quality of medical care provided to all patients
- ☐ Payment (as defined in HIPAA at 45 CFR 164.501)
- ☐ Eligibility for certain health care services (e.g., hospice)(please specify:)
- ☐ Eligibility for clinical trials (if limited, please specify here:)
- ☐ Scientific research with proper Institutional Review Board approval or waiver .
- ☐ Personal Health Record for my use or Personal Use

☐ Other, please specify: _____

EFFECTIVE PERIOD: This authorization/permission form will remain in effect until (check one):

- ☐ 12 Months from date signed
- ☐ The earlier of my death or the day I withdraw my permission
- ☐ Specific Date (mm/dd/yyyy)_____
- ☐ Specific Event:_____

WITHDRAWING YOUR PERMISSION: I can withdraw my permission at any time by giving written notice to the person or organization to whom I originally gave this form.

In addition:

- I authorize the use of a copy (including electronic copy) of this form for the disclosure of the information described above.
- I understand that there are some circumstances in which this information may be redisclosed to other parties
- My choice to sign this form will not be a basis for denial of health services.
- **I understand that refusing to sign this form does not stop disclosure of my health information that is otherwise permitted by law without my specific authorization or permission.**
- **I have read both pages of this form and agree to the disclosures above from the types of sources listed**.

X_____ _____

Signature of Patient or Patient's Legal Representative — Date Signed (mm/dd/yyyy)

_____ _____

Printed Patient or Legal Representative Name(if applicable) — Capacity of Legal Representative(if applicable) (Parent of minor, Guardian, Other (explain)

This general and special authorization to disclose was developed to comply with the provisions regarding disclosure of medical, educational, and other information under 45 CFR Parts 160 and 164 ("HIPAA"); Health Information Technology for Economic and Clinical Health (HITECH) Act, Title XIII of Division A and Title IV of Division B of the American Recovery and Reinvestment Act of 2009 (ARRA), Pub. L. No. 111-5 (Feb. 17, 2009) §13405 ("HITECH Act"); 42 U.S. Code §290dd-2; 42 CFR Part 2; 38 U.S. Code section 7332; 38 CFR 1.475 (Veterans Affairs); 20 U.S. Code §1232g ("FERPA"); 34 CFR parts 99 and 300); and all other Statutes, Constitution, regulations or administrative rules of this State requiring patient authorization, consent or permission to release such records .

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