Livingston Hospital
DEACONESS KENTUCKY PARTNER

131 Hospital Drive Salem, KY 42078
(270) 988-2299

HIPAA AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Date: ____/____/_____ (MM/DD/YYYY)

I. **THE PATIENT**. This form is for use when such authorization is required and complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards.

Patient's Name: _____
Date of Birth: ____/____/_____ (MM/DD/YYYY)
Social Security Number: ____-____-____

II. **AUTHORIZATION**. I authorize _____("Authorized Party") to use or disclose the following: (check one)

☐ All my medical-related information.
☐ My medical information ONLY related to: _____.

☐ Emergency Room Record	☐ Face Sheet
☐ Lab or Pathology Reports	☐ Radiology Images
☐ History and Physical	☐ Radiology Reports
☐ Operative Record	☐ Discharge Summary
☐ Walk In Clinic Record	☐ Cardiology Records
☐ To view chart only	☐ Itemized Statements

☐ Other: (SPECIFY)

_____
_____
_____
_____

☐ My medical-related information from ____/____/_____ to ____/____/_____.

Hereinafter known as the "Medical Records."

III. **DISCLOSURE**. The Authorized Party has my authorization to disclose Medical Records to: (check one)

☐ Any party that is approved by the Authorized Party.

☐ ONLY the following party:
Name: _____
Address: _____
Phone: (____) _____ - _____ Fax: (____) _____ - _____
E-Mail: _____

IV. PURPOSE. The reason for this authorization is: (check one)

☐ **General Purpose**. At my request (general).

☐ **To Receive Payment**. To allow the Authorized Party to communicate with me for marketing purposes when they receive payment from a third party.

☐ **To Sell Medical Records**. To allow the Authorized Party to sell my Medical Records. I understand that the Authorized Party will receive compensation for the disclosure of my Medical Records and will stop any future sales if I revoke this authorization.

☐ **Other**: _____.

V. TERMINATION. This authorization will terminate: (check one)

☐ Upon sending a written revocation to the Authorization Party.
☐ On the following date: _____/_____/_____.
☐ Other: _____.

VI. ACKNOWLEDGMENT OF RIGHTS.

I understand that I have the right to revoke this authorization, in writing and at any time, except where uses or disclosures have already been made based upon my original permission. I might not be able to revoke this authorization if its purpose was to obtain insurance.

I understand that uses and disclosures already made based upon my original permission cannot be taken back.

I understand that it is possible that Medical Records and information used or disclosed with my permission may be re-disclosed by a recipient and no longer protected by the HIPAA Privacy Standards.

I understand that treatment by any party may not be conditioned upon my signing of this authorization (unless treatment is sought only to create Medical Records for a third party or to take part in a research study) and that I may have the right to refuse to sign this authorization.

I will receive a copy of this authorization after I have signed it. A copy of this authorization is as valid as the original.

Signature of Patient: _____ Date: _____/_____/_____

Print Name: _____

(IF THE PATIENT IS UNABLE TO SIGN, USE THE SIGNATURE AREA BELOW)

The patient is unable to sign due to: (check one)

☐ **Being a Minor**. Patient is _____ years old and considered a minor under state law.

☐ **Being Incapacitated**. Patient is incapacitated due to: _____.

☐ **Other**: _____.

Signature of Representative: _____ Date: _____/_____/_____

Print Name: _____

Relationship to Patient: ☐ Parent ☐ Spouse ☐ Guardian ☐ Other: _____.

ADDITIONAL CONSENT FOR CERTAIN CONDITIONS

I. **SENSITIVE INFORMATION**. This medical record may contain information about physical or sexual abuse, alcoholism, drug abuse, sexually transmitted diseases, abortion, or mental health treatment. Separate consent must be given before this information can be released.

(check one)

☐ **I consent** to have the above information released.

☐ **I <u>do not</u> consent** to have the above information released.

Signature of Patient: _____ Date: _____/_____/_____

Print Name: _____

II. **HIV/AIDS**. This medical record may contain information concerning HIV testing and/or AIDS diagnosis or treatment. Separate consent must be given to have this information released.

(check one)

☐ **I consent** to have the above information released.

☐ **I <u>do not</u> consent** to have the above information released.

Signature of Patient: _____ Date: _____/_____/_____

Print Name: _____

Model Attestation Regarding a Requested Use or Disclosure of Protected Health Information Potentially Related to Reproductive Health

The entire form must be completed for the attestation to be valid.

I Name of person(s) or specific identification of the class of persons to receive the requested PHI.

_____

e.g., name of investigator and/or agency making the request

Name or other specific identification of the person or class of persons from whom you are requesting the use or disclosure.

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e.g., name of covered entity or business associate that maintains the PHI and/or name of their workforce member who handles requests for PHI

Description of specific PHI requested, including name(s) of individual(s), if practicable, or a description of the class of individuals, whose protected health information you are requesting.

_____

_____

e.g., visit summary for [name of individual] on [date]; list of individuals who obtained [name of prescription medication] between [date range]

I attest that the use or disclosure of PHI that I am requesting is not for a purpose prohibited by the HIPAA Privacy Rule at 45 CFR 164.502(a)(S)(iii) because of one of the following (check one box):

☐ The purpose of the use or disclosure of protected health information is **not** to investigate or impose liability on any person for the mere act of seeking, obtaining, providing, or facilitating reproductive health care or to identify any person for such purposes.

☐ The purpose of the use or disclosure of protected health information to investigate or impose liability on any person for the mere act of seeking, obtaining, providing, or facilitating reproductive health care, or to identify any person for such purposes, but the reproductive health care at issue was **not lawful** under the circumstances in which it was provided.

I understand that I may be subject to criminal penalties pursuant to 42 U.S.C. 1320d-6 if I knowingly and in violation of HIPAA obtain individually identifiable health information relating to an individual or disclose individually identifiable health information to another person.

Signature of the person requesting the PHI

Signature: _____ Date _____/_____/_____

If you have signed as a representative of the person requesting PHI, provide a description of your authority to act for that person.

_____

_____

This attestation document may be provided in electronic format, and electronically signed by the person requesting protected health information when the electronic signature is valid under applicable Federal and state law.