UC Physicians
Healing • Teaching • Leading

UC Physicians
Affiliated Covered Entity

This Affiliated Covered Entity (ACE) is comprised of the following Groups:
University Anesthesia Associates, Inc., University Dermatology Consultants, Inc., University Emergency Physicians, Inc., University Family Physicians, Inc., University Internal Medicine Associates, Inc., University Neurology, Inc., Greater Cincinnati OB/GYN, Inc., University Eye Physicians, Inc., University Orthopaedics Consultants of Cincinnati, Inc., University Ear, Nose, & Throat Specialists, Inc., Academic Pathology Associates, Inc., University Rehabilitation, Inc., Psychiatric Professional Services, Inc., University Radiology Associates of Cincinnati, and University of Cincinnati Surgeons, Inc., University Anesthesia Group, Inc., University Physicians, Inc., University Surgeon and Dental Associates, Inc.

AUTHORIZATION FOR MEDICAL RECORD RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

This authorization regarding the use and or disclosure of your Protected Health Information is required under Federal laws.
See policy on "Authorization for Release of PHI" for information on when to use this form.

Protected Health Information ("PHI") under HIPAA is defined as information that is received from, or created or received by the ACE which relates to past, present or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present or future payment for the provision of health care to an individual; and that identifies the individual, or there is a reasonable basis to believe the information can be used to identify the individual. PHI includes information of persons living or deceased. The following components of a patient's information also are considered PHI: a) names; b) street address, city, county, precinct, zip code; c) dates directly related to an patient, including birth date, admission date, discharge date, and date of death; d) telephone numbers, fax numbers, and electronic mail addresses; e) Social Security numbers; f) medical record numbers; g) health plan beneficiary numbers; h) account numbers; i) certificate/license numbers; j) vehicle identifiers and serial numbers, including license plate numbers; k) device identifiers and serial numbers; l) Web Universal Resource Locators (URLs); m) biometric identifiers, including finger and voice prints; n) full face photographic images and any comparable images; and o) any other unique identifying number, characteristic, or code.

1. I hereby authorize UC Physicians ACE to use and/or disclose my protected health information as described below. I understand that this authorization is voluntary and that it may include information relating to ***AIDS, HIV infection, behavioral health services/psychiatric care, and treatment for alcohol and/or drug abuse***. I understand that if the person/entity that receives my Protected Health Information is not covered by Federal privacy regulations, the PHI described below may be redisclosed by such person or entity. I understand that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits unless the treatment is for research purposes or unless the provision of treatment is related solely to the disclosure of my PHI to a third party such as when requested by my employer.

PATIENT INFORMATION

LAST NAME _____ FIRST _____ MIDDLE _____

MAIDEN _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

DATE OF BIRTH _____ SS NUMBER _____

PHONE _____

2. The Group(s) UC Physicians ACE is comprised of numerous Groups as listed at the top of this form. Please indicate below those entities from which you desire Protected Health Information to be used and or disclosed by/to another third party as specified.

   If this authorization is to allow disclosure of your PHI, indicate the Group(s) of UC Physicians ACE that you authorize to disclose your PHI.

   _____

   _____

   If this authorization is to allow a certain use of your PHI, indicate the Group(s) of UC Physicians ACE that you authorize to use your PHI.

   _____

   _____

3. This authorization covers the following periods of healthcare:

   From: _____ To: _____

   From: _____ To: _____

4. **Protected Health Information to be used or disclosed:**
   Check box to indicate PHI that may be used or disclosed:
   - ☐ Office Visits
   - ☐ Consultation Reports
   - ☐ Radiology Reports
   - ☐ Radiology Images
   - ☐ Laboratory Reports
   - ☐ Other (Please Specify) _____

5. This PHI may be disclosed to the following individual or organization:

Name:_____ _____

Address:_____ _____

City, State, Zip:_____ _____

Phone:_____ _____

6. This information is being disclosed for the following purposes:

- ☐ Legal Reasons
- ☐ Continued Care and Treatment
- ☐ Insurance
- ☐ Workman's Compensation
- ☐ Personal Use
- ☐ Disability
- ☐ At the Request of the Patient

This information is to be used within UC Physicians ACE for the following purpose:

- ☐ Fundraising
- ☐ Marketing
- ☐ Other _____

Explanation:_____

I understand that I/my legal representative may revoke this authorization in writing at any time, except to the extent that action has been taken in reliance on this authorization or according to law. Written revocation must be sent to _____ at _____.

The UC Physicians ACE and all of its employees, officers, and physician are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized by this form.

If I have questions about disclosure of my health information, I may contact the Medical Records Custodian of any of the Groups within the ACE or the Privacy Officer of UC Physicians ACE.

This authorization will expire in 120 days unless otherwise specified **(insert date or specific event)** _____

I hereby certify that I have read the provisions set forth in this authorization. I understand and agree to its terms.

_____

Patient's Signature Date

If you are signing as a legal representative for an individual, read and sign below:

I,_____, hereby certify and attest that I am the duly authorized legal representative of _____ and that I have the lawful authority regarding the use and or disclosure of Protected Health Information of such individual for the purposes set forth in this document.

_____

Signature

_____

Print Name Date

***** You Should Receive a Copy of this Authorization Form after Signing**

Received by _____

Practice Group _____

Date Received _____