Completion Date:

Authorization for Third Party Disclosures

(Attachment 46)

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:

Patient Name: _____ DOB: _____

Phone: _____ Fax: _____

Address: _____ Zip Code: _____

Email: _____ Medical Record #: _____

Purpose: ☐ Continued care ☐ Insurance ☐ Legal ☐ School ☐ Disability ☐ Personal ☐ Other

*Person(s)/entity authorized to **release** records*:

☐ University of Miami UHealth System

Department: _____ Name: _____

Phone: _____ Fax: _____

Purpose: ☐ Continued care ☐ Insurance ☐ Legal ☐ School ☐ Disability ☐ Personal ☐ Other

☐ ***Third party Disclosure**- Person(s)/entity authorized to **receive** records*

Name: _____ Phone: _____

Address: _____ Fax: _____

City/State/Zip _____ Email: _____

Attention: _____ Relationship: _____

Description of information to be used or disclosed. Write date(s) and/or physician name(s) here:

☐ ***Family Account Management** - I authorize the following person(s) to receive information about my treatment care*

Name: _____ Phone: _____

Address: _____ Fax: _____

City/State/Zip: _____ Email: _____

Date of birth: _____ Relationship: _____

Please check off any box below if you do not want that sensitive information shared with the person/entity that is to receive your records.

☐ 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.

☐ Genetic testing or information

This authorization will expire on the following date, event or condition: _____. 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 re-disclosed 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 Department of Health Information Management except to the extent that action has been taken in reliance on this authorization.

I understand it may take a few days for my revocation of this authorization to take effect and I will not hold UHealth responsible for any disclosure that it makes prior to the complete processing of any such revocation.

_____ _____ _____ AM/PM

Signature of Patient or Representative Date Time

_____ _____

Name of Personal Representative (if applicable) Relationship to Patient

HEALTH INFORMATION MANAGEMENT

P: 305.243.5272 uchartecopy@med.miami.edu **F:305.243.5274**

AUTHORIZATION FOR 3RD PARTY DISCLOSURES

Form D3900052E
Revised 09/18/24

Patient Identification Sticker