# *MADISON PARISH HOSPITAL AND MPH RURAL HEALTH CLINIC*
# *AUTHORIZATION TO USE AND/OR DISCLOSE HEALTH INFORMATION*

**Revocation**
Date Revoked:__________________
Initials of Privacy Official________

Patient Name: ___________________________________ Date of Birth: ________________________

Address:
________________________________________________________________________________

Disclosure for treatment dates: __________________ to ___________________

Facility Name (please circle): Madison Parish Hospital Madison Parish Hospital Rural Health Clinic

I authorize this Facility to use or disclose my health information as described below.

1. **Type of information:** The type of information to be used or disclosed is as follows (check the appropriate spaces and include other information where indicated):

______ The entire medical record (all information)
_____ Activity documentation
_____ Assessments, flow sheets
_____ Physician's orders
_____ Care Plan
_____ History and physical
_____ Social Services documentation
_____ Medication and treatment records
_____ Business Office File
_____ Nursing documentation/progress notes
_____ Nutritional services documentation
_____ Physician and professional consult progress notes
_____ Rehabilitative and restorative therapy documentation
_____ Discharge Summary
_____ Emergency Department Record
_____ Other: (Describe as specifically as possible)

Diagnostic reports (specify) : ______ Laboratory _______ Respiratory ______ X-Ray ______ EKG

________________________________________________________________________________
________________________________________________________________________________

2. **Recipient of information** - The information identified above may be used by, or disclosed to, the following individual(s) or organization(s):

Name: ____________________________________ Name: ____________________________________

Address:___________________________________ Address:___________________________________

____________________________________ ____________________________________

Name: ____________________________________ Name: ____________________________________

Address:___________________________________ Address:___________________________________

____________________________________ ____________________________________

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3. **Purpose of use/disclosure -** This information described on the previous page will be used for the following purpose(s):

 ____ Initiated at the request of the patient.

 ____ My personal records

 ____ Sharing with other health care providers as needed

 ____ Other (please describe):_______________________________________________________________

Authorization Statements/Signatures:

4. I understand that once the above information is disclosed, it may be re-disclosed by the recipient and the HIPAA Privacy Rule may no longer protect the information.

5. **For Marketing disclosures only:** ***(Check if applicable)*** ______I understand that the Facility will receive compensation related to the use or disclosure of the requested information.

6. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to a licensed Facility staff member. I understand that the revocation will not apply to information that has already been released in response to this authorization.

7. Unless I specify differently, this authorization will expire (insert date or event):

 ______________________________________________________________

8. I understand that the Facility will not condition the provision of treatment or payment on the provision of this authorization.

______________________________________________________ ____________________________

Signature of Patient or Personal Representative Date

______________________________________________________

Print Name

______________________________________________________

Personal Representative's Title (e.g., Guardian, Executor of Estate, Health Care Power of Attorney)

______________________________________________________ ____________________________

Witness Signature Date

______________________________________________________

Print Name

Revised 11/01/2016

**Distribution of copies: Original to patient's Medical Record, copy to patient.**

## *CHECKLIST FOR VALID AUTHORIZATION*

**Patient Name:** ______________________________ **Medical Record No.** ____________________

**Date of Birth:** _____________________ **Disclosure for treatment dates** _________________

When you receive a request for release of Medical Records containing PHI from any entity other than the patient or the patient's personal representative, and the disclosure is not for purposes of treatment, payment or health care operations or another disclosure required or permitted by the HIPAA Privacy Rule, <u>you may not release those records unless the requestor has provided a valid authorization</u>. Use this checklist to assure that the authorization is valid. **If any one element is missing, the Privacy Rule prohibits you from disclosing the information.** You should contact the requestor and explain why you cannot disclose the information.

_____The authorization must be written in plain language.

**All of the following elements must be included in the authorization:**

_____A specific and meaningful description of the information to be disclosed.

_____The name or other specific identification of the person (or organization or class of persons) authorized to make the requested disclosure.

_____The name or other specific identification of the person (or organization or class of persons) to whom the information will be disclosed.

_____The purpose of the requested disclosure. (If the patient initiates the authorization, the statement "at the request of the patient" is a sufficient description of the purpose).

_____An expiration date or an expiration event that relates to the patient or the purpose of the disclosure.

_____Signature of the patient or personal representative and date.

_____If signed by personal representative, a description of the representative's authority to act for the patient.

**Required Statements:**

_____A statement that information disclosed pursuant to the authorization may be subject to redisclosure and may no longer be protected by the Privacy Rule.

_____A statement of the patient's right to revoke the authorization in writing <u>and</u> either,

    _____A reference to the revocation right and procedures described in the Notice of Privacy Practices;

**OR**

    _____A statement about the exceptions to the right to revoke and a description of how the patient may revoke.

_____One of the following statements, or a substantially similar statement:

- If the Covered Entity is not permitted to condition treatment or payment on the provision of an authorization: I understand that the Facility will not condition the provision of treatment or payment on the provision of this authorization.

**OR**

- If the Covered Entity is permitted to condition the provision of research-related treatment on the provision of an authorization: I understand that the Facility will not provide research-related treatment to me unless I provide this authorization.

**OR**

- If the Covered Entity is permitted to condition the provision of health care that is solely for the purpose of creating PHI for disclosure to a third party on the provision of an authorization: I understand that the Facility will not provide health care that is solely for the purpose of creating PHI for disclosure to *a third party* to me unless I provide this authorization.

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**Defective Authorizations**

If an authorization has any one of the following defects, it is invalid and any use or disclosure made pursuant to the authorization will be in violation of the Privacy Rule:

_____The authorization has expired.

_____One of the required elements or statements is missing.

_____The Facility has knowledge that the authorization has been revoked.

_____The authorization violates the regulations governing conditioning treatment or payment upon signing the authorization, or combining authorizations.

_____The Facility has knowledge that information in the authorization is false.

______________________________________ ________________________

**Hospital or Clinic Representative Signature** **Date**