Authorization to Use/Disclose Protected Health Information

Effective Date of This Revision: 1.2023

Contact:	HIPAA Privacy & Security Officer or Compliance Officer 636 Ave. San Patricio San Juan, PR. 00920 (787) 783-3233		
Responsible Department: Compliance			
Applies to:	☒ Officers	☒ Staff	☒ Student Clinicians
	☒ Other agents	☒ Visitors	☒ Contractors
	☒ Volunteers	All Medical Records Staff & those receiving Medical Records	

AUTHORIZATION TO USE/DISCLOSE PROTECTED HEALTH INFORMATION

I authorize:_____

(NAME OF PERSON/ENTITY DISCLOSING INFORMATION)

to use and disclose a copy of the specific health information described below regarding: _____

_____

(NAME OF INDIVIDUAL/PATIENT/PLAN MEMBER)

Consisting of: _____

_____

_____

(DESCRIBE INFORMATION TO BE USED/DISCLOSED)

To ORGANIZATION for the purpose of: _____

_____

_____

_____

(DESCRIBE EACH PURPOSE OF DISCLOSURE)

If the information to be disclosed contains any of the types of records or information listed below, additional laws relating to the use and disclosure of the information may apply. I understand and agree that this information will be disclosed if I place my initials in the applicable space next to the type of information.

_____ HIV/AIDS information

_____ Mental health information

_____ Genetic testing information

_____ Drug/alcohol diagnosis, treatment, or referral

PROVIDER INFORMATION You do not need to sign this authorization. Refusal to sign the authorization will not adversely affect your ability to receive health care services or reimbursement for services. The only circumstance when refusal to sign means you will not receive health care services is if the health care services are solely for the purpose of providing health information to someone else and the authorization is necessary to make that disclosure.

You may revoke this authorization in writing at any time. If you revoke your authorization, the information described above may no longer be used or disclosed for the purposes described in this written authorization. Any use or disclosure made in accordance with this authorization and prior to any revocation cannot be undone. To revoke this authorization, please send a written statement to _____ (contact person) at _____ (address of person/entity disclosing information) and state that you are revoking this authorization.

SIGNATURE

I have read this authorization and I understand it. Unless revoked, this authorization expires:

(INSERT EITHER APPLICABLE DATE OR EVENT)

By: _____ Date: _____
(INDIVIDUAL OR PERSONAL REPRESENTATIVE)

Description of personal representative's authority:

Printed Name: