

Date Completed if Records Sent: _____

(FOR OFFICE USE ONLY.)

**Attachment 46
Authorization for 3rd Party Disclosures - Short Form**

I authorize the use or disclosure of health information about me as described below.

1. Person(s) or class of persons authorized to use or disclose the information (**Note: e.g., medical records department, physician**):

2. Person(s) or class of persons authorized to receive the information (**Note: e.g., family member, attorney, employer, researcher**):

If you would like your records to be sent to a third party, please provide address or fax where you would like us to send the information.

Name: _____

Phone: _____

Address: _____

Fax: _____

3. Description of information that may be used or disclosed (**Note: e.g., all information related to a specific type of treatment**):

4. The information will be used or disclosed for the following purposes: (**Note: if a patient initiates the request, the statement "at the request of the patient" is sufficient**)

5. 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 redisclosed and no longer protected by these regulations.

6. *[If applicable]* The disclosure of my information for marketing purposes is expected to result in a direct or indirect financial benefit to _____ *[insert the name of the disclosing covered entity].*

7. 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.

8. I understand that I may revoke this authorization at any time by sending a written request to the University of Miami privacy officer, except to the extent that action has been taken in reliance on this authorization.

9. This authorization expires _____ *[insert a date or describe an event or activity related to the patient or purpose of the authorization].* If not completed, this authorization will expire one year from date signed.

Signature of Patient or Representative

Date

Patient's Name

Patient Address

Patient Contact Phone Number

Social Security Number

Date of Birth

Name of Personal Representative (if applicable)

Relationship to Patient

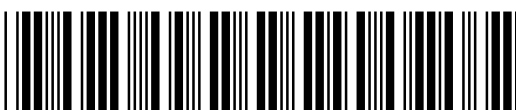
(A copy of this signed form will be provided to the patient)

University of Miami - Office of HIPAA Privacy and Security
PO BOX 019132 (M879) hipaaprivacy@med.miami.edu
Miami, FL 33101 (305) 243-5000

**AUTHORIZATION FOR 3rd PARTY DISCLOSURES –
SHORT FORM**

Form
D3900052E

Revised
08/01/05



NAME: _____

MRN: _____ IDX SMS

SS: _____

AGE: _____ DOB: ____/____/____

DATE OF SERVICE: ____/____/____