

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

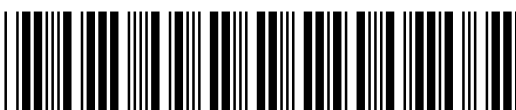
(A copy of this signed form will be provided to the patient)

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: \_\_\_\_/\_\_\_\_/\_\_\_\_