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 Address_____

Patient's Name

_____

_____ _____ _____

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: _____/_____/_____