MAYFIELD

Authorization for use and disclosure of Protected Health Information (PHI)

This Authorization is HIPAA Compliant.

This authorization regarding the use and or disclosure of your Protected Health Information is required under Federal laws.

I hereby authorize Mayfield Clinic to use and/or disclose my protected health information as described below. I understand that this authorization is voluntary and that it may include information relating to **AIDS, HIV infection, behavioral health services/psychiatric care, and treatment for alcohol and/or drug abuse.** I understand that if the person/entity that receives my Protected Health Information is not covered by Federal privacy regulations, the PHI described below may be redisclosed by such person or entity. I understand that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits unless the treatment is for research purposes or unless the provision of treatment is related solely to the disclosure of my PHI to a third party such as when requested by my employer.

Patient Information

Last Name _____ First _____ Middle _____

Maiden Name _____ Address _____

City _____ State _____ Zip _____

SS Number _____-_____-_____

Date of Birth _____/_____/_____

Phone ( ) _____-_____

FOR INTERNAL USE ONLY

MRN _____

This authorization covers the following periods of healthcare: ☐ All Periods of Healthcare

☐ From _____/_____/_____ To _____/_____/_____ ☐ From _____/_____/_____ To _____/_____/_____

Protected Health Information (PHI) to be used or disclosed (check box or boxes):

☐ Entire Medical Record (includes all below except radiology images, psychotherapy notes and neuropsychology documents)

☐ Office Visits

☐ Consultation Reports

☐ Radiology Reports

☐ Radiology Images

☐ Laboratory Reports

☐ Operative Reports

☐ Priority Consult History and Documents

☐ Psychotherapy Notes

☐ Neuropsychology Records (excluding psychotherapy notes)

☐ Billing Records

☐ Other (Please Specify)_____

This PHI may be disclosed to the following individual or organization:

Name _____ Address _____

City _____ State _____ Zip _____ Phone ( ) _____

This information is being disclosed for the following purposes: :

☐ Legal Reasons

☐ Continued Care and Treatment

☐ Psychotherapy Notes

☐ At the Request of the Patient

Explanation _____

I understand that I/my legal representative may revoke this authorization in writing at any time, except to the extent that action has been taken in reliance on this authorization or according to law. Written revocation must be sent to the Mayfield Clinic Privacy Officer, 3825 Edwards Road, Suite 300, Cincinnati, Ohio 45209.

Mayfield and all of its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized by this form.

If I have questions about disclosure of my protected health information, I may contact the Mayfield Clinic Privacy Officer, 3825 Edwards Road, Suite 300, Cincinnati, Ohio 45209.

This authorization will expire in 60 days unless otherwise specified:

Date or Specific Event _____

I hereby certify that I have read the provisions set forth in this authorization. I understand and agree to its terms.

Patient Signature _____ Date ____/____/____

If you are signing as a legal representative for an individual, read and sign below:

I,_____, hereby certify and attest that I am the duly authorized legal representative of _____ and that I have the lawful authority regarding the use and or disclosure of Protected Health Information of such individual for the purposes set forth in this document.

Signature _____ Date ____/____/____

Print Name _____

YOU SHOULD RECEIVE A COPY OF THIS AUTHORIZATION FORM AFTER SIGNING.

Received By _____ Date Received ____/____/____

Processed By _____ Date Processed ____/____/____