*CONDIS*

UC Health

# AUTHORIZATION OF DISCLOSURE TO FAMILY/FRIENDS

**LOCATION:** ☐ Daniel Drake Center ☐ University of Cincinnati Medical Center ☐ West Chester Hospital ☐ UCP

Please complete all sections of this Health Insurance Portability and Accountability Act of 1996 (HIPAA) authorization form. ***If any sections are left blank, this form will be invalid and it will not be possible for your information to be shared as requested***.

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At my own request and for my own purposes, I hereby authorize _____

(Hospital/Clinic Name) to disclose my following protected health information

( ) Condition, Treatment, Plan of Care

( ) Diagnostic Test Results

( ) Lab Results

( ) Billing Information

( ) You may leave test or procedure results on my voicemail or answering machine

To the following people:

| **Name:** | **Relationship:** |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

I understand that this authorization is voluntary and that it may include information relating to HIV/AIDS, behavioral health services/psychiatric care, and treatment for alcohol or drug abuse. I understand that if the person/entity that receives my protected health information is not covered by federal privacy regulations (i.e.-HIPAA), the protected health information selected above may be re-disclosed by the recipient.
I understand that I or my legal representative may revoke this authorization in writing at any time, except to the extent that action has already been taken in reliance on this authorization or according to law. Written revocation must be sent to the person or facility that I authorized to release my information.
I understand that UC Health will not condition treatment, payment, or healthcare operations on whether I complete this authorization.

**This authorization will expire after one year from the date of signature, unless another expiration date is specified here**: _____

Patient Name/Legal Representative: _____

Relationship to Patient: _____

Patient Date of Birth: _____

Time: _____ Date: _____Signature: _____