Patient Label

Stanford HEALTH CARE

Protected Health Information (PHI) Disclosure

Note: HIPAA Authority for Right of Access: 45 C.F.R. § 164.524

I, _____ direct my healthcare
Print Patient Name

_____
Date of Birth

and medical services providers and payers to disclose my protected health information described below:

Health Information to be disclosed as follows:

I. Authorize the release of (check A or B):

❑ **A**. **Disclose** my complete health record (including but not limited to diagnoses, lab tests, prognosis, treatment, and billing, for all conditions)

❑ **B. Disclose** my health record, as above, **BUT do not disclose** the following: (check as appropriate):

- ❑ Mental Health records
- ❑ Communicable Diseases (including HIV and AIDS)
- ❑ Alcohol and Drug Abuse Treatment
- ❑ Other:_____

II. to the following persons:

❑Patient only; designated phone number (____)_____

❑Name:_____Relationship:_____

❑Name:_____Relationship:_____

Initial here_____to authorize detailed messages regarding test results can be left on the phone number or with persons listed above.

III. This authorization shall be effective until (check one):

❑ All past, present, and future periods

❑ Date or event:_____unless I revoke it.

(NOTE: You may revoke this authorization in writing at any time by notifying your health care providers, preferably in writing.)

_____ _____
Patient Signature or Legal Representative Date

_____ _____
Name of Legal Representative Relationship

University HealthCare Alliance ("UHA") is a medical foundation affiliated with Stanford Health Care and Stanford Medicine. UHA contracts with a number of physician groups to provide the medical care in the UHA clinics. Neither UHA, Stanford Health Care, nor Stanford University employ the physicians in the clinics and do not exercise control over the professional services provided by the physician groups.