Authorization for Use or Disclosure of Protected Health Information (PHI)

Date ______________ Date of Birth: ___________________

Patient Name ____

Address ____

I ____ authorize The Care Team to use or

(Patient/Representative Name)

disclose my health information as described below.

Type of Information to be used or disclosed:

☐ The entire clinical/medical record (all information)

☐ Only the events from_________ to __________

☐ Business Office File

☐ Diagnostic reports (lab, x-ray, etc.)

☐ Nursing documentation/progress notes

☐ Physician/NP and professional progress notes

☐ History and Physical

☐ Medication and Treatment records

☐ Other (describe as specifically as possible):

____

If you would like any of the following sensitive information disclosed, check the applicable box(es) below:

☐ Alcohol/Drug Abuse Treatment/Referral

☐ Sexually Transmitted Diseases

☐ HIV / AIDS-related Treatment

☐ Mental Health (Other than Psychotherapy Notes)

☐ Other ____

Recipient of Information – The information may be used by, or disclosed to, the following individual(s) or organizations(s):

☐ The Care Team and its Subsidiaries ☐ Name and Address:

☐ Name and Address: ☐ Name and Address:

Authorization Agreement

- The Person making this authorization request is (check one): ☐ The individual (Patient) ☐ Someone representing the individual.
- I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure by the recipient and the information may not be protected by federal confidentiality rules.
- I understand that I may revoke this authorization at any time by notifying The Care Team in writing if I choose to do so, my request to revoke will not apply to information that has already been released in response to this authorization.
- I understand that I may refuse to sign this authorization. My refusal does not affect my treatment, payment or eligibility for care.
- Unless I specify differently, this authorization will expire one year from the date of my signature.

____ ________________

Signature of Patient or Personal Representative Date

____

Print Name

____

Personal Representative relationship to individual

Distribution of copies: Original to individual's record, copy to individual

Access to Protected Health Information (PHI) Request Form

Date ______________ Date of Birth: ____________________

Patient Name ____

Address ____

I ____ request that The Care Team provide me with access to

(Patient/Representative Name)

my protected Health Information as checked below:

- ☐ The entire clinical/medical record (all information)
- ☐ Assessments
- ☐ Business Office File
- ☐ Diagnostic reports (lab, x-ray, etc.)
- ☐ History and Physical
- ☐ Medication and Treatment records
- ☐ Nursing documentation/progress notes
- ☐ Physician and professional progress notes
- ☐ Physician's orders
- ☐ Rehabilitative and restorative therapy documentation
- ☐ Social Services documentation

Other (describe as specifically as possible):

____

I request access to my health information as indicated above covering these dates:

From: ______________________ through ______________________

Type of Access Requested

☐ Inspection of requested information with The Care Team medical staff

☐ Copies of requested information maintained by The Care Team

Signature of Patient/Personal Representative ____________________ Date ____________________

Print Name ____________________

Personal Representative relationship to patient ____________________

Distribution of copies: Original to individual's record, copy to individual

Request to Restrict Use and Disclosure of Protected Health Information (PHI)

Section A: Patient (or representative) to complete the following information

Date ______________ Date of Birth: ___________________

Patient Name ____

Address ____

Information Restriction

I am requesting a restriction on the use/disclosure of my protected health information in the manner described below. I understand that The Care Team may deny this request. If my request is approved, I understand that the restriction will not apply in cases where I need emergency treatment.

Restrictions for Treatment, Payment or Operation will only apply for visits/encounters that were paid for in full by me; out of pocket.

Description of Specific Health Information to be Restricted:

____

____

Persons/Organizations Restricted from Use/Disclosure: ______________________________

____

Other Restrictions (please specify):

____

____

____

____ ____________________
Signature of Patient or Personal Representative Date

____
Print Name

____
Personal Representative relationship to patient

Section B: The Care Team to complete the following information

Your request for restriction has been:

☐ Accepted* ☐ Denied

**In the case of an emergency or when necessary to comply with the law, we may use and disclose your health information despite the restrictions requested herein until you terminate these restrictions.*

____ ____________________
Signature of the Compliance Manager Date

____
Print Name

Section C: The Care Team and the Patient, if possible, complete this section

Termination of Restriction

☐ The above named patient agreed to terminate this restriction on: ___________________________

☐ The above named patient was notified on ___________________ (date) that this restriction was terminated. Patient was notified:

- ☐ In person
- ☐ By telephone (attach documentation)
- ☐ By Mail (attach documentation)

____ _______________________
Signature of The Care Team Representative Date

____
Print Name

____ _______________________
If possible, Signature of Patient or Personal Representative Date

____
Print Name

____
Personal Representative relationship to patient

____ _______________________

Distribution of copies: Original to individual's record, copy to individual

Request for Amendment of Protected Health Information (PHI)

Section A: Patient (or representative) to complete the following information

Date: ___________________________ Date of Birth: ______________________

Patient Name & Address:

____

____

I hereby request that The Care Team amend the following information in my Designated Record Set:

☐ My clinical records	☐ My business office files

Dates of information to be amended (i.e., date of visit, treatment, or other health care services):

____

I request this amendment for the following reason(s):

____

The information should be amended as follows (please include attachment if necessary):

If the request for amendment is made as described above, would you like the amended information sent to anyone else who has received the information in the past: ▪ No
▪ Yes

If yes, please specify the name and address of the organization(s) or individual(s) below.

I understand that The Care Team may or may not supplement my record with an addendum based on my request. I also understand that The Care Team is not able to alter the original documentation in a record under any circumstances. Regardless of whether my request is granted or denied, I understand that this request will be made a part of my permanent Medical Record and will be sent as part of the Medical Record in response to any authorized requests for release of my Protected Health Information (PHI).

Signature of Individual or Personal Representative Date

Print Name

Personal Representative relationship to individual

Section B: For The Care Team Use Only:

Date Request Received: ___________

Request for correction/amendment has been:

☐ Accepted ▪ Denied

If denied, check reason:

☐ The PHI was not created by The Care Team.	☐ The PHI is not part of Individual's designated record set
☐ The PHI is not available to the Individual for inspection as required by Federal law	☐ The PHI on file is accurate and complete

Notice to Individual/Others

Individual and/or others notified of determination via one or more of the following (check all that apply):

☐ Amendment Acceptance Letter sent to Individual on this date:	
☐ Amendment Acceptance with Consent to Notify sent to Individual on this date:	
☐ Notification of Amendment sent to identified persons pursuant to Individual's authorization on this date:	
☐ Amendment Denial Letter sent to Individual on this date:	

____

Signature of Medical Director or Designee Date

____

Print Name _______________________________________

Comments of the Healthcare Provider/Medical Director (if applicable):

____

____

____

____ ________________

Name & signature of Provider/Medical Director (if applicable) Title
Date

Distribution of copies: Original to individual's record, copy to individual

Request for Accounting of Disclosure

PATIENT INFORMATION

Date of Request: ______________________

Name: ____ Date of Birth: __________________

Address: ____

____

Address to send disclosure accounting (if different from above):

____

____

DATES REQUESTED

I would like an accounting of all disclosures for the following time frame. *Please note: the maximum requested is six years prior to the date of your request.*

From: ____________________________ To: ____

FEES

There is no charge for the first accounting request in a 12-month period. For subsequent requests in charge is $__________. I understand that there is (check one):

_____ No fee for this request

_____ A fee for this request in the amount specified above and I wish to proceed.

RESPONSE TIME

I understand the accounting I have requested will be provided to me within 60 days unless I am noti
of up to 30 days is needed.

_______________________________________ _____________________

Signature of Patient or Legal Representative Date

FOR ADMINISTRATIVE USE ONLY

Date request received: _________________ Date accounting sent: ________________

Extension requested: ____ Yes ____ No

If yes, give reason: ____

Patient notified in writing on this date: _______________

Staff member processing request: ______________________________________

Distribution of copies: Original to individual's record, copy to individual