

Completion Date:

Attachment 46
Authorization for 3rd Party Disclosures



UNIVERSITY OF MIAMI
MILLER SCHOOL
of MEDICINE

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 (e.g., UHealth medical records, physician):

2. Person(s) or class of persons authorized to receive the information (e.g., name & relationship: family, attorney, employer, etc.):

If you would like your records to be sent to a third party, please provide an address or fax where you would like us to send the information. Please attach additional pages if more than one third party.

Name: Address:
City: State: Zip:
Phone: Fax:

3. Description of information that may be used or disclosed (e.g., all information related to a specific type of treatment):

The following must be separately initialed by you if applicable to your authorization:

- HIV/AIDS STATUS - HIV related information, which includes any information indicating that I have had an HIV-related test, or HIV infection, HIV-related illness or AIDS, or any information which would indicate that I have been potentially exposed to HIV.
Sexually transmitted diseases Sexual assault information
Mental health treatment records governed under state law (including mental health records relating to involuntary or voluntary mental health treatment). Mental health records may include substance abuse information.
Substance abuse (drug and alcohol) treatment records. Substance abuse information may be part of mental health records.

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. [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].

6. 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.

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. 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. I understand that I may revoke this authorization at any time by sending a written request to the University of Miami Office of HIPAA Privacy and Security, PO Box 019132 (M-879) Miami, FL. 33101, except to the extent that action has been taken in reliance on this authorization.

Signature of Patient or Representative

Date

Patient Name

Patient Address

Patient Contact Phone Number

Last 4 Digits of SSN Date of Birth

Name of Personal Representative (if applicable)

Relationship to Patient

University of Miami - Office of HIPAA Privacy & Security
PO Box 019132 (M-879) hipaaprivacy@med.miami.edu
Miami, FL 33101 305-243-5000 1-866-366-4874

AUTHORIZATION FOR 3RD PARTY DISCLOSURES



Form D3900052E

Revised 6/03/14

NAME:

MRN:

LAST 4 DIGITS OF SSN:

DOB: / /

DATE: TIME:

## **How to Obtain your Medical Records**

If you are requesting a copy of your medical records, you will be required to complete an Attachment 19 or Attachment 46 (3<sup>rd</sup> Party Authorization) form to obtain copies of your record. You may also be asked to provide a photo ID for identification purposes.

*Please complete the form, fax, mail or contact the appropriate medical record department listed below:*

### **University of Miami Hospital and Clinics (UMHC)/Sylvester Comprehensive Cancer Center (SCCC)**

1475 N.W. 12<sup>th</sup> Avenue

Miami, Florida 33136

Phone: 305-243-5272

Fax: 305-243-5274 & 305-243-9521

Website: [www.sylvester.org](http://www.sylvester.org)

### **Bascom Palmer Eye Institute (BPEI)/Anne Bates Leach Eye Hospital (ABLEH)**

900 N.W. 17<sup>th</sup> Street

Miami, Florida 33136

Phone: 305-326-6333

Fax: 305-547-3709

Website: <http://bascompalmer.org/>

### **University of Miami Hospital (UMH)**

1400 N.W. 12<sup>th</sup> Ave

Miami, FL 33136

Phone: 305-689-5605 & 305-689-5187

Fax: 305-689-4490 & 305-689-3995

Website: <http://www.umiamihospital.com/>

**For any other clinical department, please contact the physician office directly.**

**For further assistance, please call 305-243-4000.**

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*For privacy issues or concerns, please contact:*

#### **Office of HIPAA Privacy and Security**

Phone: 305-243-5000 Outside of Dade County: 866-366-4874

Fax: 305-243-7487

Email: [hipaaprivacy@med.miami.edu](mailto:hipaaprivacy@med.miami.edu)

Website: [www.privacyoffice.med.miami.edu](http://www.privacyoffice.med.miami.edu)

P.O. Box 019132 (M-879)

Miami, Florida 33101

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#### **MyUHealthChart online portal**

You may also access portions of your health information online through the MyUHealthChart portal. <https://myuhealthchart.com/mychart/>

For further assistance or to obtain access, email: [AskMyUHealthChart@med.miami.edu](mailto:AskMyUHealthChart@med.miami.edu)