

FORM 3312 Rev. 7/11

## THE QUEEN'S MEDICAL CENTER

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## **AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION**

l auth	orize *	to release/obtain the protected health information of
	(*Provider/Health can	e facility)
	*Patient Name:	Birthdate:
	Address:	Phone #:
<i>T</i> o:	*Name or Institution:	
	Address:	City, State, Zip:
*	Information to be disclosed:	
D	ate(s) of Service:	*Purposes for Use and/or Disclosure:
	Operative Reports	atory Results  Ulmaging Reports  Record  Dynamics  Dynam
	Please specify:	
Cente autho provid	er (QMC) will not condition my treatmen rization except as allowed under federa	hat I can refuse to sign this authorization and The Queen's Medical t, payment, enrollment or eligibility for benefits on the signing of this disprivacy laws for: (i) research-related treatment; or (ii) health care or (iii) health plan initial enrollment/eligibility determinations,
writing	g, of my revocation. This is described in	tion at any time by notifying the QMC Medical Records Department, in the QMC Notice of Privacy Practices. I understand that the revocation was released in reliance on this authorization.
	erstand that the health information relea no longer be protected under federal pr	sed under this authorization may be re-disclosed by the recipient and ivacy regulations.
the di		r from all liability and all claims of any nature whatsoever pertaining to ssional opinions, findings, or recommendations as contained in the cal Center.
*Sign	ature:	* Print Name
*Relationship:		requestor is not patient Date
*Item	s that MUST be completed for authoriza	

Distribution: White — Medical Records • Yellow — Patient