

Authorization Expiration Date or Event:

(NOTE: After this date or event has passed, this authorization to use/disclose will no longer be valid. Unless otherwise specified, an authorization will be valid for 6 months after the date it is signed. If authorization is for research purposes, the statement "end of the research study or "none" or similar language will extend your permission beyond 6 months.)

The patient or the patient's representative must read and initial the following statements:

Initials: _____ I understand that I may revoke this Authorization at any time by notifying the UMC Privacy Officer in writing, but if I do, it will not have any affect to the extent UMC took action in reliance on the Authorization.

Initials: _____ I understand that UMC may not condition the provision of treatment, payment, enrollment in a health plan, or eligibility for benefits on signing this Authorization, except under the following circumstances:

- participating in research projects can be conditioned on my signing an Authorization to use and disclose PHI in the research
- initial enrollment in health plans can be conditioned on signing an Authorization for the health plan to review PHI to make eligibility detenninations
- furnishing healthcare services to me at the request of a third party can be conditioned on me signing an Authorization for disclosure of the PHI to the third party requesting the treatment.

Signature of patient or patient's representative: _____ Date: _____

Printed Name of patient's representative: _____

Relationship to the patient/description of authority to act for patient: _____