Underground Vaults & Storage, Inc.

1841 Taylor Avenue Building 4 Louisville, KY 40213-1565 Fax: 502-451-5257

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION Pursuant to 45 C.F.R. 164.508

	Name of Health Care Provider/Physician/Facility/Medicare or Medicaid Contractor			
	Street Address	City	State Zip Code	
Re:	Patient Name:			
	Date of Birth:	Social Security No:		
such I here	person(s) or organization(s) may be by authorize Underground Vault	and state health information privace not be protected by those laws. as & Storage, Inc., its agents and e th information to the following per	employees, as the custodian of my	
Name	e(s)			
Orga	nization(s)			
Addr	ess(es)			
1.	required) including, but not inpatient, outpatient and emenotes, nurses notes, clinical reresults, correspondence, recorrespondence, recorrespondence.	than psychotherapy notes for w limited to, office notes, history ergency treatment, clinical charts ecords, treatment plans, admission rds received from other medical proto the Patient's care and treatment	and physical, consultation notes s, reports, order sheets, progress on records, discharge records, tes roviders and all other information	

UVS/HIPPA Authorization Rev. 06212013

2.	Specific description of the purpose for each use or disclosure (or write "At the request of the individual" in this space):		
3.	I understand that I may revoke this authorization in writing at any time by sending a signed and dated written statement to Underground Vaults & Storage, Inc., stating that I am revoking my authorization to disclose health records, except to the extent protected health information has been released in reliance on this authorization. I further understand that my eligibility for health benefits, my enrollment in a health plan, and my treatment will not be affected by whether or not I sign this authorization.		
4.	Unless sooner revoked, this authorization expires on the date one year subsequent to the date of this Authorization. This Authorization is given in compliance with the consent requirements for release of alcohol or substance abuse records of 42 CFR 2.31, the restrictions of which have been considered and expressly waived.		
	had the opportunity to read and consider the contents of this authorization and confirm that the ts are consistent with my direction.		
	Dated: tor Legal Representative Signature (See 45 CFR 164.508(c)(1)(vi)		
Patient	tor Legar Representative Signature (See 45 CFR 164.508(c)(1)(vi)		
-	sentative's Relationship to Patient CFR 164.508(c)(1)(iv)		
Printed	1 Name:		
Addres	ss:		
Teleph	one:Email:		
Other (Contact Information		
Notes:			

^{1.} Protected health information ("PHI") is health information that is created or received by a health care provider, health plan, or health care clearinghouse which relates to: 1) the past, present, or future physical or mental health of an individual; 2) the provision of health care to an individual; or 3) the past, present, or future payment for the provision of health care to an individual. To be protected, the information must be that it identifies the individual or provides a reasonable basis to believe that the information can identify the individual. 45 C.F.R. 164.508

^{2.} These laws apply to health plans, health care providers, and health care clearinghouses.