PANEL 14

Form Approved OMB No. 0935-0118 Exp. Date XX/XX/20XX

## AUTHORIZATION TO OBTAIN INFORMATION FROM MEDICAL AND BILLING RECORDS MEDICAL EXPENDITURE PANEL SURVEY – U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Street Address:  City:  Telephone:  Area Code  B. I am voluntarily participating in the Medical Expenditure Panel Survey (MEPS), a study of health care use and expenses being conducted by the U.S. Department of Health and Human Services. I authorize and request that you provide the U.S. Department of Health and Human Services and its contractors with medical and financial information they request shout all health services provided to under the during the period January 1, 2009 to December 31, 2010. This authorization from covers any care I received at your facility during this period, including treatment for mendal health, alcohol, drug abose, STD. HIV. or ALDS. It also covers care I received during this period from any medical provider associated with your facility or who provided care to me in your facility.  I understand that the Health Ilmsurance Portability and Accountability and to 1996 (HIPAA) <sup>(1)</sup> prohibits you from releasing my information without my authorization. This form (or a photocopy of this form) glves you my authorization. I have signed this form voluntarily, with the understanding that my decision to sign or not to sign the form will have no effect on my eligibility for returning parameters of Health and Human Services and its contractors will use this information to supplement the information I have already given for MEPS research on health care use and expenditures. I also understand that once my information is released to the study, it is no longer covered by HIPAA but is covered by the Public Health Service Act <sup>(2)</sup> , which prohibits the release of information in the would identify me or my medical provides outside the sponsoring agency and its contractors without my permission or that of my medical providers and will be kept confidential to the extent permitted by law.  I authorize the study to use information I have given in the survey to help you identify my records. I also understand that I can revoke this authorization at any time by contacting a study representative hydrogen and the	A.	A. Provider Name:								
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D. 4. Patient's Signature - 14 and over sign  IF PATIENT IS 14-17, BOTH PATIENT AND PARENT/GUARDIAN MUST SIGN AND DATE.  E. 6. Parent, Guardian, Witness or Proxy's Signature  Parent, Guardian, Witness or Proxy's Signature  9. Reason for Parent, Guardian, Witness or Proxy's Signature:  8. Patient 13 or Younger Patient Disabled Patient Disabled Patient 14-17 Years Old Patient Deceased  FIELD USE ONLY: RU ID: PROVID: PID:  (1) Health Insurance Portability and Accountability Act: 42 U.S.C. 1320d-2 and 1320d-4 and the implementing regulation, 45 CFR 164.508, require a detailed authorization for your health care provider to disclose health information from your records for research purposes.  (2) Public Health Service (PHS) Act: Sections 934(c) and 308(d) [42 U.S.C. 2996-3(c), and 42 U.S.C. 242m(d)] protect the confidentiality of data collected under the research authorities of the Agency for Healthcare Research and Quality and the National Center for Health Statistics. Section 543 of the PHS Act [42 U.S.C. 290dd-2,] and regulations at 42 CFR Part 2, provide additional confidentiality restrictions on records of alcohol and substance abuse patients. This research project will be carried out in compliance with all these provisions.	C.	1. Pa	atient Name:							
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SCAN:   Yes   No	(1)									

Public reporting burden for this collection of information is estimated to average 3 minutes per response, the estimated time required to complete the survey. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to: AHRQ Reports Clearance Officer Attention: PRA, Paperwork Reduction Project (0935-0118) AHRO, 540 Gaither Road, Room # 5036, Rockville, MD 20850.