



Written Authorization to Release Copies of Healthcare Information

Patient name: _____ Date of birth: _____
 (First, MI, Last, Maiden if applicable)

I authorize _____, its designated employees or agents to release copies of health care information to:

Name (if different than Patient) _____

Patient Parent Guardian Other (relationship) _____

Address _____

City, State, Zip _____

Daytime phone no. _____

The purpose(s) of the release is _____

Date(s) of service _____ Illness/condition (if applicable) _____

Type of Service (Protocol)

Inpatient/Short Stay/Observation Admission Outpatient Service ED Visit Post Hospital Placement/Care

Physician Reports

Discharge Summary History & Physical Operative Emergency Dept. Consultation Dr. Office Notes

Diagnostic Reports

Laboratory Radiology Reports Radiology Films Cardiology Pathology

Home Care and Hospice Reports

Assessments Plans of Care Progress Notes/Summaries Medication Profiles Physician Orders

Other information to be disclosed (specify): _____

Information that I refuse to disclose (specify): _____

Statements I added: _____

If I have been diagnosed or treated for any of the following I understand that St. Joseph Healthcare needs my specific consent to disclose related information. Please check and initial the following statements indicating to the releaser to authorize or not to authorize release/disclosure of said sensitive information. Such information may not be re-disclosed by the recipient without my specific written consent.

I Do Do not Not applicable **authorize disclosure of information which refers to treatment or diagnosis of drug or alcohol abuse**
 Initials _____

I Do Do not Not applicable **authorize disclosure of information which refers to treatment or diagnosis of psychiatric illness.**
 Initials _____

I Do Do not Not applicable **authorize disclosure of information which refers to treatment or diagnosis of HIV infection, ARC or AIDS**
 Initials _____

I Do Do not **want to review such information before it is released. I understand that any review must be supervised by designated staff.**
 Initials _____

I understand that my medical record contains information relating to my diagnosis and treatment and authorize the release of all such information listed above except those items I have crossed out or specified. I further understand that I may review my records and refuse authorization to disclose all or some of the above health care information, but that refusal may result in improper diagnosis or treatment, denial of coverage or claim for health benefits from other insurance(s) or other adverse consequences. Partial or incomplete records will be labeled as such.

If I am a parent or legal guardian requesting access to a minor's information, I further understand that I will not be provided access to records related to certain categories of treatment as required by law (for example, a minor's reproductive health records).

I understand that St. Joseph Healthcare may deny this request under limited circumstances as provided for under federal and state law protecting the privacy of health information. I understand that in such cases, I may designate a representative to review my records on my behalf.

I understand that, if this information is disclosed to a third party, the information may no longer be protected by federal privacy regulations and may be redisclosed by the person or organization that receives the information.

I understand that St. Joseph Healthcare will notify me of its decision to approve or deny my request to access or obtain a copy of the Requested Information within thirty (30) days of receiving this request if the information is maintained or accessible on-site at St. Joseph Healthcare or within sixty (60) days if the Requested Information is not maintained or accessible on-site at St. Joseph Healthcare. If St. Joseph Healthcare is unable to comply with my approved request for information maintained or accessible on-site within thirty (30) days, it may extend the applicable deadline for up to thirty (30) more days by notifying me in writing.

This authorization expires in (90) days. Subsequent disclosures by Releaser are permitted until expiration. However, I understand that I can revoke this Authorization at any time prior to the above time frame by notifying the appropriate medical records department of the revocation. Such revocation must be in writing, signed, and dated and shall be effective when received, subject to the rights of any such person who acted in reliance on the Authorization prior to receiving notice of revocation. I understand that revocation may be the basis of denial of health benefits, insurance coverage, benefits, and/or other adverse consequences and that I would be responsible for payment for services received.

I understand that I am entitled to a copy of this authorization form.

(Patient Signature)

Date

(Authorized Representative/Relationship)

Date

(Witness)

Date

MR# _____ Processed on _____ Processed by _____