

All portions of this form **must** be completed to constitute a valid authorization for release of health information under the Health Insurance Portability and Accountability Act (HIPAA) privacy regulations. If any field is left blank, the authorization will be considered defective.

Patient's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Medical Record # \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Telephone No. \_\_\_\_\_ Email Address \_\_\_\_\_

I authorize the use and disclosure of health information about me as described below:

**St Joseph Hospital**

Facility Authorized to Release my Health Information

Agency or Individual(s) Authorized to Receive my Health Information

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Telephone Number \_\_\_\_\_

Health Information that may be used / disclosed is limited to the following:  Progress Notes  Emergency Room Record  
 Discharge Summary  History & Physical  Consultation(s)  Lab  Pathology Report  
 Operative Note(s)  Imaging/X-ray films  X-ray Reports  Entire Record  Fetal Heart Monitor Strips  
 Other, (specify) \_\_\_\_\_

Health Information that may be used / disclosed is limited to the following periods of healthcare:

From (date): \_\_\_\_\_ To (date): \_\_\_\_\_ Account Number: \_\_\_\_\_

From (date): \_\_\_\_\_ To (date): \_\_\_\_\_ Account Number: \_\_\_\_\_

Health Information to be released to the above named agency/individual is to be used/disclosed for the following purpose(s):

Treatment/Consultation  At Request of Patient  Research  Marketing  Billing of Claims Payment  
 At Request of Employer  Other \_\_\_\_\_

"Health Information" identifies you (the patient) by name, and includes other demographic information about you. "Health Information" may include, but is not limited to: medical records, x-ray films, slides, tracings, strips, etc.

I hereby discharge the releasing facility, its agents and employees from any and all liabilities, responsibilities, damages and claims which might arise from the release of information authorized herein, **to include alcohol, drug abuse, communicable disease including HIV status, and/or psychiatric diagnoses** compiled during my visit, encounter or hospitalization, or make copies thereof in accordance with the policies of this facility.

If applicable, I agree to the release of my medical or billing records containing the **sensitive information** listed above.

Yes  No

Protected Health Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and is no longer protected by this privacy rule. If research-related Health Information is used or disclosed for continued research purposes, an expiration date or event does not apply.

This authorization will automatically expire 60 days after the date of signature below (except as indicated above), unless an earlier date is specified, or at the conclusion of a specified event. I understand that I have a right to revoke this authorization at any time, in writing, as stated in the Notice of Privacy Practices, except where the facility has already made disclosures in reliance upon my prior authorization.

Treatment, payment, enrollment or eligibility for benefits may not be conditioned on obtaining an authorization if the Health Information Portability Accountability Act prohibits such conditioning. If conditioning is permitted, refusal to sign the authorization may result in denial of care or coverage.

NOTICE TO RECEIVING AGENCY OR INDIVIDUAL: This information is to be treated in accordance with Health Insurance Portability and Accountability Act (HIPAA) privacy regulations.

Patient's or Authorized Personal Representative's Signature\* \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_

Relationship to Patient | Authority to Act on Patient's Behalf \_\_\_\_\_ Interpreter, if Utilized \_\_\_\_\_

Witness's Signature \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_ Expiration Date or Event \_\_\_\_\_

Signature must be validated against driver's license or signature in Medical Record.  
There may be a charge for copying Medical Records.

\_\_\_\_\_  
first initial, last name

Electronic Copy Requested

Form Number 4200-0008-1 Rev. 12/04/14

PHI-Auth for Use and Disclosure



// ?  
ATT:;  
PCP:;  
REF:  
ALERT: