Saint Alphonsus Medical Group

I authorize the use or release/disclosure of protected health information regarding the named individual as described below.

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

Patient's Full Name (Including maiden name)

Have you been here under any other name(s)?

Birth date | Medical Record Number

The following person or organization is authorized to DISCLOSE the specified information:

Name:

Street Address:

City, State, Zip:

Phone: Fax:

The following person or organization is authorized to RECEIVE the information:

Name:

Street Address:

City, State, Zip:

Phone: Fax:

This information is to be used for the following purpose(s) only:

The specific information to be released/disclosed is specified below: ☐ Complete Medical Record

☐ Outpatient Medical Record
Date(s): _____
- ☐ Discharge Summary
- ☐ History and Physical
- ☐ Operative Report
- ☐ Pathology Report
- ☐ Progress Notes
- ☐ Orders
- ☐ Laboratory
- ☐ X-rays,
- ☐ Pertinent Record Set

☐ Diagnostic Tests

Test	Date
☐ Laboratory	
☐ X-rays	
☐ CT Scans	
☐ Nuclear Med	
☐ EEG	
☐ EKG	
☐ Vascular Study	
☐ Sleep Study	
☐ Echocardiogram	
☐ Pulmonary Test	

- ☐ Other: _____
- ☐ Other: _____
- ☐ Other: _____
- ☐ Other: _____
- ☐ _____
- ☐ _____

I understand that the information described above may be re-disclosed in which case it is no longer protected by patient privacy regulations.

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my consent to the use or disclosure of my protected health information for purposes of treatment, payment or health care operation's, nor is my treatment or payment for treatment conditional on my signing this authorization.

I understand that I may revoke this authorization in writing at any time at the address found below, except to the extent that information has already been released and/or used in response to this authorization, or an authorization, otherwise received by Saint Alphonsus. Unless otherwise revoked, this authorization will expire on the following date or event: _____ If I fail to specify an expiration date/event, this authorization will expire in twenty-four (24) months.

SPECIFIC AUTHORIZATION

I understand that my health information to be released MAY INCLUDE information that is related to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), behavioral or mental health services, and/or treatment for alcohol and/or drug abuse. My signature below authorizes release of all such information, unless I have crossed it out, and initialed it. _____Initials

_____ _____
Signature of Patient or Legal Representative | Date

_____ _____
Name of Personal Representative (if applicable) (Please print) | Relationship to Patient

WHITE – Health Information Management **YELLOW** - Patient

People assisting with paperwork:

_____ _____ _____
Interpreter's name | Interpreter's signature and/or ID # | Date and Time

_____ _____ _____
Office Staff name | Office Staff signature | Date and Time

Place patient sticker here or handwrite

Name: _____

DOB: _____