ST. VINCENT'S
HEALTHCARE

Authorization for Release of Protected Health Information

TO:

NAME OF PHYSICIAN OR FACILITY

STREET ADDRESS

CITY **STATE** **ZIP**

PHONE NUMBER **FAX NUMBER**

Patient Name:	**Birth Date:**
Social Security # (last 4 digits only):	**Telephone #**
Address: **City:** **State:** **Zip:**	

I hereby authorize the above-referenced entity to release the medical information about me indicated below to the following recipient:

Recipient Name: St. Vincent's Medical Center	**Telephone #:**
Address: **City:** **State:** **Zip:**	**Fax #:**

FOR THE FOLLOWING PURPOSE: ☐ Continued Care *

***DATES OF SERVICE NEEDED**

☐ All Dates of Service ☐ Last Visit Only ☐ **From** _____ **to** _____

Medical Information to be Released:

☐ Complete Record *(no films)*	☐ Emergency Department Record	
☐ History & Physical	☐ EKG Reports *(no films)*	☐ Cardiovascular Reports
☐ Discharge Summary	☐ Radiology Reports *(no films)*	☐ Pathology Reports
☐ Consult Report	☐ Mammography Reports *(no films)*	☐ Anesthesia Record
☐ Operative/Procedure Report	☐ Laboratory Reports	

☐ Other: _____

I am aware that such records may include information relating to the diagnosis, treatment and/or examination of alcohol and drug use; mental health (psychiatry/psychology/psychotherapy); HIV (Human Immunodeficiency Virus) and AIDS (Acquired Immune Deficiency Syndrome); and sexually transmissible diseases, and I specifically authorize the release of such information.

I understand that this Authorization will remain in effect for one (1) year, but I may revoke it any time in writing. I further understand that any such revocation will not apply to any information already released under this Authorization. I acknowledge that I am under no obligation to sign this Authorization and that my ability to obtain treatment from St. Vincent's HealthCare and its affiliates will not depend in any way on whether I sign the Authorization or not.

Federal and State laws prohibit the Recipient of this information from using it for other than the stated purpose. The law also prohibits recipients from making any further disclosure of this information without the specific written consent of the patient. However, I understand that St. Vincent's HealthCare and its affiliates cannot guarantee that recipients of the information will not use or re-disclose it contrary to such legal prohibitions, and the information may no longer by protected by privacy laws once it has been so used or re-disclosed.

The law also prohibits the disclosure of mental health records to certain individuals in some circumstances, which may include patients and their family members. I hereby release St. Vincent's HealthCare and its affiliates, and their contractors and employees, from any and all liability that may arise from the release of information as I have directed.

I have read and understand this authorization. I hereby authorize the release of the above-requested medial information about me.

Signature of Patient

Signature of Patient's Representative

Date

Representative's Name / Relationship to Patient

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Rev: 10/2013

(PLEASE USE DEPARTMENT FAX COVER SHEET FOR HIPAA COMPLIANCE)

2900

Incoming