Authorization for Release of Information

Section A: Must be completed by patient or patient's legal representative for all authorizations

Patient Name:_____ Date of Birth:_____

Patient Address:_____

Patient Phone Number:_____ Medical Record#:_____

I hereby authorize_____

(name of physician, hospital or health care provider)

to release my personal health and medical information as described below to the following person(s) or health care provider(s).

_____

(Name and address(es) of person(s) to receive information)

Information to be disclosed:

- ☐ complete health record(s)
- ☐ discharge summary
- ☐ history & physical examination
- ☐ consultation reports
- ☐ progress notes
- ☐ laboratory tests
- ☐ X-ray reports
- ☐ X-ray films
- ☐ Pathology report
- ☐ Pathology slides
- ☐ Paraffin block
- ☐ operative report
- ☐ other (please specify) _____

covering the period(s) of health care

From (date) _____ to (date) _____

From (date) _____ to (date) _____

I understand that this will include information relating to (check if applicable):

- ☐ acquired immunodeficiency syndrome (AIDS) or infection with human immunodeficiency virus (HIV)
- ☐ behavioral health services/psychiatric care
- ☐ diagnosis/treatment for alcohol and/or drug abuse

The patient or the patient's representative must read and initial the following statements:

a. I understand that this authorization is voluntary. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits. _____ Initials

b. I understand that I may inspect or receive a copy of the information described on this form if I ask for it, and that I will receive a copy of this form after I sign it. _____ Initials

c. Unless otherwise cancelled, I understand that this authorization will expire on the following date, event, or condition: _____ Initials

_____

Unless a shorter expiration date or event is specified above, this authorization will expire one (1) year from the date of this authorization.

Saint John Hospital

ON107

Authorization for Release of Information

NS3134SJ / 0514

PATIENT INFORMATION

Authorization for Release of Information

d. I understand that I may cancel this authorization at any time by notifying the providing health care provider in writing, but if I do, it won't have any effect on actions taken prior to receipt of the cancellation. _____ Initials

e. I understand that if the person or entity that receives the above information is not a health care provider or a health plan covered by federal privacy regulations, the released information may be redisclosed by such person or entity and will likely no longer be protected by the federal privacy regulations. The recipient may otherwise be prohibited under federal law from redisclosing substance abuse information, AIDS/HIV status, or mental health information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law. _____ Initials

Section B: This section must be completed only if a health plan or a health care provider has requested the authorization; the requesting party must complete this section.

1. The health plan or health car provider must complete the following:

a. What is the purpose of the use or disclosure? _____

_____

b. Will the health plan or health care provider requesting the authorization receive financial or in-kind compensation in exchange for using or disclosing the health information described above? ☐ Yes ☐ No

_____ Date/Time: _____

Signature of patient/parent/legal representative

If signed by other than patient, indicate relationship: _____

Address of legal representative: _____

Telephone number of legal representative: _____

Printed name of legal representative: _____

Witness: _____ Date/Time: _____

_____ Date/Time: _____

Signature of Providence Health representative

For internal use only

_____ _____

(copied by and date) (released by and date)

Saint John Hospital

ON107

PATIENT INFORMATION