



3-Hole 5/16 4 1/4 c-to-c

This authorizes _____ to:
PERSON(S), CLASS OR ORGANIZATION

- OBTAIN a copy of my Protected Health Information contained in my medical record to:**
- RELEASE a copy of my Protected Health Information contained in my medical record to:**

Name _____ Address _____

Date(s) of Treatment _____ Inpatient Outpatient Emergency Room
 Other (specify) _____

The information to be released or disclosed is:

- Radiology reports Emergency room reports Operative reports Lab reports
- Abstract (transcribed reports, test results, EKGs, face sheets)
- Other _____

The information indicated above is to be used and/or disclosed for the following purpose(s):

COMPLETE THE FOLLOWING INFORMATION IF ST. ANTHONY'S MEDICAL CENTER IS REQUESTING THE AUTHORIZATION:

To be completed by St. Anthony's Medical Center:

Is St. Anthony's Medical Center receiving some form of compensation in exchange for using or disclosing the Protected Health Information described above? (check one) YES NO

To be read by patient prior to signing:

I understand that I may refuse to sign this authorization.

I understand that my treatment at or by St. Anthony's Medical Center or payment for that treatment will not be affected if I do not sign this authorization.

I understand that I may request to inspect and copy the information that is to be used and/or disclosed pursuant to this authorization.

I understand that I should receive a copy of this authorization after I sign it.

This authorization expires on _____ or within 90 days of the date signed if I have not provided an expiration date or an expiration event.
DATE OR EVENT

Once my health information is disclosed, I understand that it may no longer be protected by privacy laws.

I understand I may revoke this authorization at any time by notifying St. Anthony's Medical Center, in writing, at the above address, but that any such revocation will not have any effect on any actions taken before receiving the revocation.

IMPORTANT: I understand that authorized disclosures may contain Protected Health Information containing diagnosis, treatment and other information regarding psychiatric and mental health, substance abuse (chemical dependency), HIV and/or AIDS, unless I specifically request that such information not be disclosed.

I understand that I can receive a copy of this authorization if I request it.

SIGNATURE OF PATIENT OR PATIENT'S REPRESENTATIVE DATE

If signed by patient's representative, indicate relationship to the patient _____

Telephone number where patient may be contacted _____



**Health Information Management Department
AUTHORIZATION FOR USE OR
DISCLOSURE OF PROTECTED
HEALTH INFORMATION**

PATIENT'S NAME (print name)

DATE OF BIRTH

MEDICAL RECORD NUMBER

SOCIAL SECURITY NUMBER

CORRESPONDENCE

5/1

5/1



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