Trinity Health Mid-Atlantic | Saint Francis Healthcare

MR: **DOB:**

FIN:

Authorization to Use or Disclose of Protected Health Information

Patient Name: ______________________ Phone #: ______________________

Date of Birth: ______________________ SS # (last 4 digits) :__________ Medical Record Number: ______________

Address: ______________________ City, State, Zip Code: ______________________

1. **I authorize the use or disclosure of the above named individual's health information as described below**
2. **The following individual(s) or organization(s) are authorized to make the disclosure:**

   ____

3. **The type of information to be used or disclosed is as follows: (check the appropriate boxes and include other information where indicated)**
   Date(s) of Service ______________________

- ☐ Face Sheet / Registration Sheet
- ☐ Discharge Summary
- ☐ ER Record
- ☐ H&P
- ☐ Consults
- ☐ Progress Notes
- ☐ Operative Report
- ☐ Pathology Report
- ☐ Medication List
- ☐ Lab Results
- ☐ EKG/ Cardiology Testing Results
- ☐ Radiology Results ☐ On CD ☐ On film ☐ On paper
- ☐ Genetic Information
- ☐ Discharge Instructions
- ☐ Home Care Records|
- ☐ Entire Record

OTHER: please specify ____

____

4. **I understand that information related to my treatment for AIDS/HIV, mental health care, or genetic information <u>will not</u> be disclosed unless specifically checked below:**

   - ☐ **AIDS/HIV - Yes, disclose this information (Initial)** ______
   - ☐ **Behavior/Mental Health Care/Treatment - Yes, disclose this information (Initial)** ______
   - ☐ **Genetic Information - Yes, disclose this information (Initial)** ______

   I understand that if my authorization includes genetic, HIV, substance abuse, or mental health information, it may include; (i) genetic information about inherited genes or chromosomes, and of alterations thereof, whether obtained from an individual or family member, that is scientifically or medically believed to predispose an individual to disease, disorder, or syndrome, or believed to be associated with a statistically-significant increased risk of development of a disease, disorder, or syndrome; (ii) information concerning whether an individual has been the subject of an human immunodeficiency virus (HIV)-related test, has HIV and/or HIV-related illness, acquired immunodeficiency syndrome (AIDS), and/or including information pertaining to the individual's contacts; (iii) substance abuse information including whether the individual is receiving treatment, prognosis, a brief description of progress, and/or a short statement as to whether the individual relapsed into substance abuse and the frequency of such relapse; (iv) behavioral health information including behavioral/mental health care information about whether or not the individual received treatment, prognosis, as well as complete information on all matters relating to the admission, legal status, care, and treatment of the individual, as well as all pertinent documents relating to the individual.

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5. **The information identified above may be used by or disclosed to the following individual(s) or organization(s):**
   Name: ______________________________
   Address: ______________________________
6. **This information for which I am authorizing disclosure will be used for the following purpose:**
   ☐ Sharing with other health care providers as needed ☐ Other (please describe) ______________
7. **I understand that I may revoke this authorization at any time. I understand to revoke this authorization, I must do so in writing and present my written revocation to the medical record department. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. An oral request for revocation can be accepted in special circumstances.**
8. This authorization will begin on the date signed below and expire on: ______________
   If no expiration date is specified, this authorization will expire one year from the signature date.
9. I understand that once the above information is disclosed, it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws or regulations.
10. I understand authorizing the use or disclosure of the above information is voluntary. I need not sign this form to ensure healthcare treatment.

____

Signature of patient or Personal Representative Date/Time

Relationship to patient, if signed by Personal Representative ______________________________

I have been offered a copy of this Authorization Form	☐ Accept	☐ Refuse
Patient (or agent/representative) identification verified	☐ Yes	☐ No
I would like to receive the records requested in an electronic format		☐ Yes

Verbal Consent - The patient has given verbal authorization to release the above identified information. I have witnessed the verbal authorization. The patient has been informed of the nature of the authorization and freely gives his/her consent.

Signature of witness ______________________________ Date/Time ______________
Signature of witness ______________________________ Date /Time ______________