St. Elizabeth PHYSICIANS

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION ST. ELIZABETH PHYSICIANS

Pt. MRN _____

HealthPort Office # _____

_____ _____ _____ _____

Printed Name of Patient | Patient's Social Security Number | Date of Birth | Today's Date

Address _____

Street Address | City | State | Zip Code | Phone

X _____ _____ _____

Signature of Patient or Patient's Representative | Relationship of Representative to Patient | Expiration Date or 90 days

X _____

Signature of Witness

MUST HAVE COMPLETE INFORMATION BEFORE THIS REQUEST CAN BE PROCESSED.

I hereby authorize the use and disclosure (release) of my Medical Record information:

From: To:

_____ _____

_____ _____

_____ _____

The information to be released includes: ___ Entire Medical Record ____ Other _____

_____

The Medical Record Information will be used and/or disclosed for the following purposes:

☐ At the request of the individual ☐ Changing Primary Care Physician ☐ Changing/seeing Specialist
☐ Other (write purpose here) _____

_____

I acknowledge and agree that the term Medical Record information may include: notes by the provider and other personnel, results, reports, correspondence, x-rays and other diagnostic imaging films, as well as claims, billing, and payment information. I expressly authorize the use and/or disclosure of information concerning HIV testing or treatment of AIDS or AIDS-related conditions, any drug or alcohol abuse, drug related conditions, alcoholism, and/or psychiatric/psychological conditions unless specifically excluded.

Please <u>exclude</u> the following information, if it is part of my Medical Record information (*Check any or all you want **excluded** from this authorization for use or disclosure*):

☐ Chemical Dependency/Substance Abuse ☐ Psychiatric/psychological conditions
☐ Sexually Transmitted Diseases ☐ Alcohol ☐ Drugs ☐ N/A

I understand that this Authorization shall remain in effect for a period of **<u>90 days</u>**. I further understand that I may revoke this Authorization at any time by notifying St. Elizabeth Physicians in writing. However, if I choose to do so, I understand that my revocation will not affect any actions taken by St. Elizabeth Physicians before receiving my revocation.

I understand that I have the right to restrict disclosure of my PHI to a health plan, if the disclosure is for payment or healthcare operations and pertains to a healthcare item or service for which I have paid out-of-pocket in full. I have the right to an accounting of disclosures of any and all breach notifications of my unsecured PHI upon my written request to the SEP Privacy Officer. I also understand I have the option to "opt-out" of receiving communications from my provider should I choose to do so as long as I provide them with the request in writing.

A PHOTO IDENTIFICATION WILL BE REQUIRED TO PICK UP MEDICAL RECORDS

_____ I am designating _____to pick up my medical record. I understand my designee or I will need to produce a picture I.D. in order to obtain the records.

Refusal to sign this authorization in no way affects my treatment, payment, or eligibility for benefits. Any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules.

Patient received free copy YES NO, dates included to Chart in MZ Storage YES NO
Return chart to: MZ Storage Office Box # Chart # _____