I, ______________________________, the PATIENT / LEGAL REPRESENTATIVE HEREBY AUTHORIZE

☐ St. Joseph Medical Center; ☐ St. Francis Hospital; ☐ St. Clare Hospital; ☐ Other ____________

**TO RELEASE INFORMATION FROM THE HEALTH RECORD OF**

______________________________
*(Patient Name)*

SSN: ____________ Date of Birth: ____________ for care received.

Anytime ________ , or from ___/___/___ through ___/___/___ .

**INFORMATION TO BE RELEASED:**

☐ Discharge Summaries ☐ Radiology Reports ☐ Emergency Records ☐ Operative Reports ☐ Lab Reports

☐ History & Physicals ☐ Consultations ☐ Pathology Reports ☐ Entire Record ☐ Other: ____________
*(please specify)*

**TO THE FOLLOWING INDIVIDUAL OR ORGANIZATION:**

Name / Organization Address City, State, Zip

**FOR THE PURPOSE OF:**

☐ Continuing Medical Care ☐ Insurance Billing ☐ Legal Matters ☐ Other ____________
*(please specify)*

I AUTHORIZE ____________ , ____________ TO PICK UP THE ABOVE RECORDS.

I understand that my express consent is required to release any health care information relating to testing, diagnosis, and/or treatment for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use. If I have been tested, diagnosed, or treated for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders/mental health, or drug and /or alcohol use, you are specifically authorized to release all health care information relating to such diagnosis, testing or treatment.

I understand that authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment. I understand that once the above information is disclosed, the information may not be protected by federal privacy laws and may potentially be redisclosed by the recipient.

**REVOCATION:** I understand that I may revoke this authorization at any time by notifying the Health Information Management Department at Franciscan Health System in writing or by completing the Revocation of Authorization form. I understand that the revocation will not apply to information that has already been released in response to this authorization.

**EXPIRATION:** This authorization will expire when the request has been filled, or on this date: ____________

PATIENT / LEGAL REPRESENTATIVE SIGNATURE DATE

Relationship (if other than patient) Phone Number

**FACILITY STAFF USE:**

Request Received by: ____________ Date: ____________

COPY OF AUTHORIZATION PROVIDED: Y_____ N_____ FEE SCHEDULE PROVIDED: Y_____ N_____

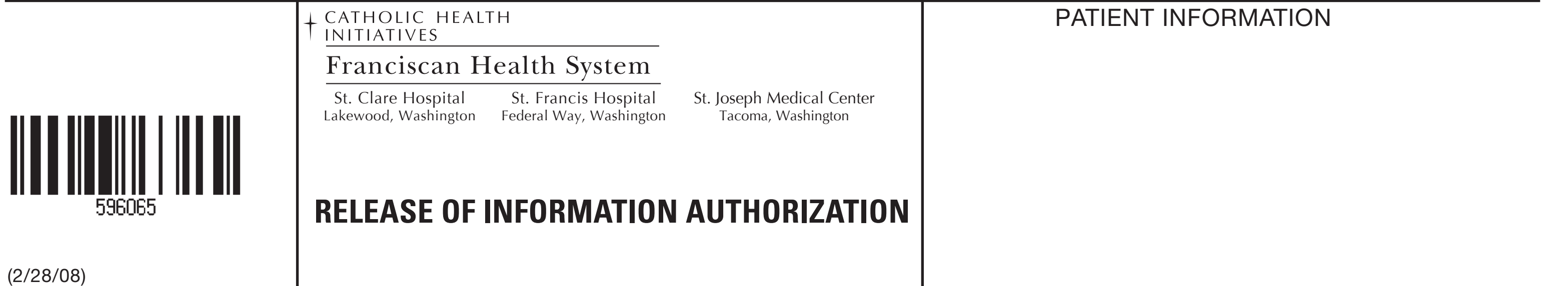
The Legal Representative presented the following documentation to demonstrate their authority to act on behalf of the patient:

☐ Power of Attorney ☐ Death Certificate ☐ Executorship ☐ Court Order

Authorized representative notified that records were ready: ____________ Date ____________ Employee initials ______

Signature of person picking up records Date

Type of photo identification verified: ☐ Drivers License ☐ Military I.D ☐ Other ____________ Employee Initials ______




PATIENT INFORMATION

**RELEASE OF INFORMATION AUTHORIZATION**

(2/28/08)