ST. ALOISIUS MEDICAL CENTER

Sisters of Mary of the Presentation Health System

AUTHORIZATION FOR RELEASE OF INFORMATION

Name of Patient_______________________________________Birthdate_________________Medical Record Number___________________________

I hereby authorize____
(Name and Address of Individual or Organization)

To release to____
(Name and Address of Individual or Organization to Receive information)

The following information from my medical record for dates of service From____________________ Through______________________.

______Clinical Resume/Discharge Summary
______History and Physical Report
______Consultation Report
______ Operative Report
______Emergency Room

_____Pathology
_____Laboratory Report
_____Radiology Report
_____EKG
_____Billing Records

Internal Use by St Aloisius Staff
Completed by:_____________________________________

____Other (Please specify)
____
____

ALL RECORDS PRETAINING TO PSYCHIATRIC/MENTAL HEALTH, ALCOHOL AND/OR DRUD DEPENDENCY, AND/OR HIV/HIV RELATED ILLNESS WILL NOT BE RELEASED UNLESS SPECIFICALLY AUTHORIZED BELOW IN WRITING.

I specifically authorize the release of the following records:

☐ Psychiatric /Psychological__________ (Initials) ☐ HIV__________ (Initials) ☐ Drug and/or Alcohol Dependency_________ (Initials)

The information is necessary for the following purpose:

_____Diagnosis and Treatment
_____Insurance
______Legal
______Military
____Personal:____
____Other:____

This authorization shall remain in effect until the following date, event or condition: ____
If no date, event, or condition is specified, this authorization will expire in one (1) year.

Of Note: Any patient s 14 years or older must authorize the release of their own sensitive information such as psychiatric, mental health, chemical dependency, contraception or STD's.

1. This authorization remains in effect until the above date, event, or condition, unless specifically revoked by written notice to the individual or organization. I understand that this authorization may be revoked at any time. I understand that if I revoke this authorization, it will not affect any actions taken prior to the revocation.
2. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this authorization in order to assure care.
3. I understand that I may inspect or request copies of any information disclosed under this authorization and that I am entitled to a copy of this authorization form once I have signed it.
4. I understand that if the individual or organization that receives the information is not a health care provider or health plan covered by federal privacy regulations the information described above may be re-disclosed and no longer protected by these federal regulations.
5. A photocopy of this authorization is as effective as the original.

____ (Signature of Patient or Legal Representative)
__________________________________ (Relationship)
___________________________________ (Date)

____
(If patient unable to sign, state reason)