ST. VINCENT'S HEALTHCARE

Authorization for Release of Protected Health Information

Check One

☐	SV RIVERSIDE	1 Shircliff Way, Suite 2716, Jacksonville, FL 32204 Attn: Medical Records Fax: (904) 308-5651
☐	SV SOUTHSIDE	4201 Belfort Road, Jacksonville, FL 32216 Attn: Medical Records Fax: (904) 296-4929
☐	SV CLAY	1670 St. Vincent's Way, Middleburg, FL 32068 Attn: Medical Records Fax: (904) 602-2734
☐	ST. CATHERINE LABOURÉ MANOR	1750 Stockton Street, Jacksonville, FL 32204 Attn: Medical Records Fax: (904) 308-4791

Patient Name:				**Birth Date:**
Social Security # (last 4 digits only):				**MRI #:**
Address:	**City:**	**State:**	**Zip:**	**Telephone #:**

I hereby authorize the above-referenced entity to release the medical information about me indicated below to the following recipient:

Recipient Name:				**Telephone #:**
Address:	**City:**	**State:**	**Zip:**	**Fax #:**
E-mail address				☐ **electronically delivered** ☐ **CD**

FOR THE FOLLOWING PURPOSE:

☐ Continued Care * ☐ Legal (Attorney) ☐ Social Security Disability ☐ Personal
☐ Insurance ☐ Dept of Children & Family Services ☐ Disability ☐ Other _____

* If for continued care, records needed for doctor's appointment on _____ (date) at _____ (time)

DATES OF SERVICE NEEDED

☐ All Dates of Service ☐ Last Visit Only ☐ **From _____ to _____**

Medical Information to be Released:

☐ Complete Record *(no films)* ☐ Emergency Department Record ☐ Cardiovascular Reports
☐ History & Physical ☐ EKG Reports *(no films)* ☐ Pathology Reports
☐ Discharge Summary ☐ Radiology Reports *(no films)* ☐ Anesthesia Record
☐ Consult Report ☐ Mammography Reports *(no films)* ☐ other:
☐ Operative/Procedure Report ☐ Laboratory Reports

ADDITIONAL REQUEST
☐ Itemized Bill
☐ UB04
☐ Radiology Films

FEE SCHEDULE: $1.00 per page – paper records **NOTE**: Fee will be waived if released to treating Doctor/Treatment Facility

Charge for medical records on CD or e-mailed---- $0.49 per page (for patient use only)

I am aware that such records may include information relating to the diagnosis, treatment and/or examination of alcohol and drug use; mental health (psychiatry/psychology/psychotherapy); HIV (Human Immunodeficiency Virus) and AIDS (Acquired Immune Deficiency Syndrome); and sexually transmissible diseases, and I specifically authorize the release of such information.

I understand that this Authorization will remain in effect for one (1) year. I also understand that I may revoke this authorization in writing at any time, except to the extent already relied upon and except as stated in St. Vincent's HealthCare's Notice of Privacy Practices. To revoke this authorization, contact entity listed above in writing.

Federal and State laws prohibit the Recipient of this information from using it for other than the stated purpose. The law also prohibits recipients from making any further disclosure of this information without the specific written consent of the patient**.** However, I understand that St. Vincent's HealthCare and its affiliates cannot guarantee that recipients of the information will not use or re-disclose it contrary to such legal prohibitions, and the information may no longer by protected by privacy laws once it has been so used or re-disclosed.

The law also prohibits the disclosure of mental health records to certain individuals in some circumstances, which may include patients and their family members. I hereby release St. Vincent's HealthCare and its affiliates, and their contractors and employees, from any and all liability that may arise from the release of information as I have directed.

I have read and understand this authorization. I hereby authorize the release of the above-requested medial information about me.

_____ _____
Signature of Patient Signature of Patient's Representative

_____ _____
Date Representative's Name / Relationship to Patient