Authorization for Use or Disclosure of Protected Health Information

Ascension Medical Group

Patient Full Name: _____ Medical Record Number: _____

Patient DOB: _____ SS# Last 4 Digits: _____ Phone Number: _____

Address: _____ City: _____ State: _____ Zip: _____

I hereby authorize the use or disclosure of the Protected Health Information described below to be provided to or obtained by the following:

Name of Individual/Facility/Company **to Receive** PHI:

_____
Name:
_____
Address
_____
City State Zip
Email/Fax# _____

Name of Individual/Facility **to Disclose PHI**:

_____
Name:
_____
Address
_____
City State Zip
Email/Fax# _____

Purpose of Request

☐ Personal ☐ Referral or 2nd Opinion ☐ Legal ☐ Insurance ☐ Transfer from Practice ☐ Other _____

Information to be Released

I authorize release of the following medical record information. I acknowledge there may be a cost to me for this activity.

☐ Please provide a five year summary from my records. I understand any fee related to this will be capped at $25.00, plus mailing costs.
☐ Please provide my entire medical record. I understand any fee related to this will be capped at $25.00, plus mailing costs.
☐ Only send medical records within this date range: _____ (Standard fees may be charged)
☐ Only send specific medical information requested: _____(Standard fees may be charged)

COPY FEE: *Pursuant to State Law establishing reasonable fees for copying medical records, and the Omnibus Provisions of HIPAA, we reserve the right to charge a cost based fee for patient requests. Please see the accompanying letter.*

Format of Information

How would you like your records delivered? (Check One) ☐ Mail ☐ Fax ☐ CD in PDF Format

☐ Via electronic transmission. I understand that by requesting email, my information will be transmitted in an encrypted format and that I will receive notice to establish a username and password to limit access to my information. If requesting unsecure email, I understand that my information could be viewed by others without the security afforded by my encryption, username and password. Regardless of the method chosen, transmission of the information may require multiple messages depending on the volume of the material involved. Please send my electronic transmission. ☐ Via Secure electronic mail ☐ Via Unsecured electronic mail

Authorization to Release Protected Health Information

*Required-Please complete the check boxes below indicating how protected information should be handled even *if* the categories do not necessarily apply to the patient's medical records.

Release Records? Check One

Initial each line below to confirm your choices

STOP

I ☐ DO	☐ **DO NOT** want **Mental Health or Psychotherapy Notes/Information** Released	_____
I ☐ DO	☐ **DO NOT** want information about*****HIV Tests & Related Information** released	_____
I ☐ DO	☐ **DO NOT** want information about *****Alcohol and/or Substance Abuse** released	_____
I ☐ DO	☐ **DO NOT** want information about *****Genetic Testing** released	_____
I ☐ DO	☐ **DO NOT** want information about **Social Worker Communication** released	_____
I ☐ DO	☐ **DO NOT** want information about **Rape/Sexual Abuse** released	_____
I ☐ DO	☐ **DO NOT** want information about **Developmental Disability** released	_____
I ☐ DO	☐ **DO NOT** want information about **Sexually Transmitted Disease (STD's)**released	_____
I ☐ DO	☐ **DO NOT** want information about _____	_____

Know Your Privacy Rights Refer to the HIPAA "PRIVACY NOTICE"

_____ _____
Sign Here **Date** Sign Here Date

_____ _____
Print name of Patient or Legal Representative Date Description of Legal Representative's Authority**

*This Authorization is Valid for **one year** unless you specify otherwise (enter expiration date) _____

** If you are the legally recognized representative of the patient you must provide supporting documentation. You may revoke this Authorization at any time by providing a written statement, except to the extent that St. John Clinic has already completed action on it. You are entitled to a copy of this authorization. ***The term "genetic tests" means only those tests which determine your future chances of developing a disease, not tests done to diagnose a current condition or problem. The information released pursuant to this Authorization may be redisclosed by the receiving institution or individual to other individuals or organizations that are not subject to privacy protection laws. St. John Clinic will not condition treatment on payment of the provision of this Authorization.