Patient Name: _____ SSN: _____

Date of Birth: _____ Phone Number: _____

1. I authorize Saint Thomas Health:

☐ Saint Thomas DeKalb ☐ Saint Thomas Hickman ☐ Saint Thomas Highlands ☐ Saint Thomas Midtown
☐ Saint Thomas River Park ☐ Saint Thomas Rutherford ☐ Saint Thomas Stones River ☐ Saint Thomas West
☐ Saint Thomas Medical Partners _____

☐ Use my health information as described below; and/or
☐ Disclose my health information to the following individual or organization:

_____

Mailing Address (required): _____

E-Mail Address: _____

2. The purpose(s) for the use or disclosure is as follows: _____

_____

3. The type and amount of information to be used or disclosed is as follows:
Health information covering treatment from

_____ , _____ to _____, _____
Date of Service Date of Service

☐ Abstract
(Includes H&P, Progress notes, Procedure reports, Consult, DS, Diagnostic Testing, and all dictated reports.)
☐ Copy of Medical Record only
☐ Copy of Complete Record (medical records and financial records)
☐ History and Physical (H&P)
☐ Discharge Summary (DS)
☐ Operative / Procedure Report (OP)
☐ Pathology Report
☐ Laboratory Report
☐ X-Ray Report
☐ Consultation

Other: _____

_____

4. I understand that my health information may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for drug and alcohol abuse.

5. I understand that I have a right to revoke this authorization at any time. I understand that, if I revoke this authorization, I must do so in writing and present my written revocation to the Health Information Management Department. I understand that my revocation will not apply to the extent that Saint Thomas Health has taken in reliance on this authorization. I understand that my revocation will not apply if this authorization was obtained as a condition of obtaining insurance coverage and the law provides my insurer with the right to contest a claim under my policy or the policy itself. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____.
If I fail to specify an expiration date, event, or condition, this authorization will expire in six months.

6. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. Saint Thomas Health may not condition treatment, payment, enrollment in its health plan, or eligibility for benefits on my signing this authorization. I understand that if I authorize Saint Thomas Health to disclose my health information, the health information may be subject to redisclosure by the recipient and may no longer be protected by certain federal privacy regulations. If I have questions about disclosure of my health information, I can contact the Health Information Management Departments of Saint Thomas Hickman at 931-729-7271 ext. 3770, Saint Thomas Midtown at 615-284-8223, Saint Thomas Rutherford at 615-396-4130, Saint Thomas West at 615-222-6434, Saint Thomas DeKalb at 615-215-5382, Saint Thomas Highlands at 931-738-4160, Saint Thomas River Park at 931-815-4133, Saint Thomas Stones River at 615-563-7226.

7. **Please ☐ Mail ☐ E-mail**

_____ _____ _____
Signature of Patient or Legal Representative Date Time

_____
If Signed by Legal Representative, Relationship to Patient

ALL BLANKS MUST BE COMPLETED

ROI2800

Ascension Saint Thomas
Authorization for Disclosure of PHI

REV - 02/04/20 Form # STHS490