Authorization for Release of Protected Health Information

Check One

- ☐ ASV RIVERSIDE — 1 Shircliff Way, Suite 1224, Jacksonville FL 32204, Attn: Medical Records, Fax: (904) 308-5651
- ☐ ASV SOUTHSIDE — 4201 Belfort Rd, Jacksonville FL 32216, Attn: Medical Records, Fax: (904) 296-4929
- ☐ ASV CLAY COUNTY — 1670 St. Vincent's Way, Middleburg FL 32068, Attn: Medical Records, Fax: (904) 602-2734
- ☐ ST. CATHERINE LABOURE PLACE — 1750 Stockton St, Jacksonville FL 32204, Attn: Medical Records, Fax: (904) 308-4791
- ☐ FSER ARLINGTON/WESTSIDE — 1 Shircliff Way, Suite 2716, Jacksonville FL 32204, Attn: Medical Records, Fax: (904) 308-5651

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)* ☐ Behavioral Health

☐ Operative/Procedure Report ☐ Laboratory Reports ☐ other: ☐ **Abstract**

ADDITIONAL REQUEST

☐ Itemized Bill

☐ UB04

☐ Radiology Films

FEE SCHEDULE: $0.12 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 --- $6.50 flat fee (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 Ascension St. Vincent'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 Ascension St. Vincent's 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

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