

Authorization For Use or Disclosure of Protected Health Information/Access to Protected Health Information

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I, _____, [Print Name of Individual (i.e., patient, resident or client)]
hereby authorize **CHI St. Joseph's Health** to use and/or disclose the individually identifiable health
information as described below for the following patient:

Patient Name: _____ DOB: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

I authorize the following person(s) or organization to receive the information:

Name: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____ Email: _____

The following individually identifiable health information may be used and/or disclosed:

Check (✓) all that apply:

- | | |
|--|---|
| <input type="checkbox"/> Abstract (Includes ¹) | <input type="checkbox"/> Emergency Room Records |
| <input type="checkbox"/> Discharge Summary /Final Diagnosis ¹ | <input type="checkbox"/> Reports of Tests & X-rays |
| <input type="checkbox"/> History and Physical Records ¹ | <input type="checkbox"/> Immunization (shot) Record |
| <input type="checkbox"/> Consultation Reports ¹ | <input type="checkbox"/> Physical Therapy Notes |
| <input type="checkbox"/> Operations and Procedures ¹ | <input type="checkbox"/> Outpatient Clinic Notes |

Other*: _____

* If authorization is for *marketing*, indicate if _____ will receive
compensation in exchange for the use and/or disclosure of the PHI. YES or NO

Dates of treatment to be released: _____

I request the form of release of information be Electronic (Portal) Electronic (Email)
 Paper (U.S. Mail or pick up) Other (CD, etc...) _____

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I authorize the release of any information contained in the above records concerning treatment of drug or alcohol abuse, drug-related conditions, alcoholism, psychiatric/psychological condition, psychiatric/mental health treatment and/or HIV-related conditions.

Reason or purpose for the use and/or disclosure of the information:

I understand a fee may be charged for copies of my medical record.

Prohibition on Conditioning of Authorization: CHI St. Joseph's Health will not condition treatment on your signing this authorization, unless:

- You are receiving research-related treatment; or
- The only reason the facility is providing you with health care is to make a report to a third party, such as your employer (e.g., fitness to return to work) or school (e.g., P.E. physical).

Re-disclosure: I understand that the information used and/or disclosed according to this authorization may no longer be protected by federal privacy law (also known as HIPAA) and the recipient of your health information may potentially re-disclose it. However, under the Federal Substance Abuse Confidentiality Requirements, 42 CFR Part 2, the recipient may be prohibited from disclosing identifiable substance abuse information.

Expiration: This authorization will expire _____ (insert date, event or "once purpose stated above is served").

Revocation: I understand that I may revoke this authorization at any time by notifying **CHI St. Joseph's Health** in writing by sending a letter to the CHI Entity specified on this release or completing the Revocation of Authorization form. I understand that if I revoke this authorization, it will not affect any actions that **CHI St. Joseph's Health** took before it received my revocation letter. For example, **CHI St. Joseph's Health** cannot rescind disclosures it has already made and may use my health information as necessary to bill and collect for services rendered.

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This Authorization is binding: The statements made in this authorization are binding, controlling and I understand that they take precedence over statements made in the **CHI St. Joseph's Health** Notice of Privacy Practices.

***SIGNATURE OF INDIVIDUAL OR PERSONAL REPRESENTATIVE:**

* _____ **DATE:** * _____

Printed name of individual's personal representative, if applicable: _____

Rationale for serving as personal representative to the individual (e.g., parent, legal guardian):

FOR INTERNAL PURPOSES ONLY

When **CHI St. Joseph's Health** is requesting an authorization to use health information for its own use, the following provision must be completed:

Staff Personnel:

Received by: _____

Date: _____

Was a signed copy provided to the individual? ___ YES

___ NO

Access approved? ___ YES

___ NO