St. Elizabeth PHYSICIANS

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Pt. MRN _____

Printed Name of Patient	Social Security Number	Date of Birth	Today's Date

Street Address	City	State	Zip Code	Phone

Signature of Patient or Patient's Representative	Relationship of Representative to Patient	Expiration Date or 90 days

MUST HAVE COMPLETE INFORMATION BEFORE THIS REQUEST CAN BE PROCESSED.

I hereby authorize the use and disclosure of my Protected Health Information:

	Release Information From:	Release Information To: (Required)
Name		
Address		
City, State, Zip		
Phone		
Fax		

The information to be released includes:

☐ Entire Chart: Last 2 years of active treatment will be provided unless specified. Dates _____

☐ Specific Department/office only (Behavioral Health, Women's Health, etc.)_____

☐ Other information requested, please specify: _____

The Protected Health Information will be used and/or disclosed for the following purposes:

☐ **At the request of the individual** ☐ **Changing Physician** ☐ **Seeing a Specialist**
☐ **Other** (write purpose here) _____

I acknowledge and agree that the term protected health information may include: notes by my provider and other personnel, results, reports, correspondence, x-rays and other diagnostic imaging films, as well as claims, billing, and payment information. I expressly authorize the use and/or disclosure of information concerning HIV testing or treatment of AIDS or AIDS-related conditions, any drug or alcohol abuse and substance abuse treatment information, drug related conditions, alcoholism, and/or psychiatric/psychological conditions.

I understand that this Authorization shall remain in effect for a period of **90 days**. I further understand that I may revoke this Authorization at any time by notifying St. Elizabeth Physicians in writing. However, if I choose to do so, I understand that my revocation will not affect any actions taken by St. Elizabeth Physicians before receiving my revocation.

I understand that I have the right to restrict disclosure of my PHI to a health plan, if the disclosure is for payment or healthcare operations and pertains to a healthcare item or service for which I have paid out-of-pocket in full. I have the right to an accounting of disclosures of any and all breach notifications of my unsecured PHI upon my written request to the SEP Privacy Officer. I also understand I have the option to "opt-out" of receiving communications from my provider should I choose to do so as long as I provide them with the request in writing.

Refusal to sign this Authorization in no way affects my treatment, payment, or eligibility for benefits. Any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. I understand that if substance use disorder treatment information is disclosed pursuant to this Authorization, it is not subject to redisclosure by the recipient without my express written consent unless otherwise permitted by Federal regulations governing Confidentiality and Substance Use Disorder Patient Records, 42 C.F.R. Part 2, or the Health Insurance Portability and Accountability Act of 1996, C.F.R. Parts 160 & 164.

A PHOTO IDENTIFICATION WILL BE REQUIRED TO PICK UP MEDICAL RECORDS

I understand my designee or I will need to produce a picture I.D. in order to obtain the records