

# **SSMHC "Request for Access to/Authorization for Use and Disclosure of Protected Health Information"**

Name of SSMHC Entity maintaining the information that is subject to this Authorization: \_\_\_\_\_

PATIENT NAME: \_\_\_\_\_

DATE OF BIRTH: _____	LAST MO	FIRST DAY	MI YR	Maiden or Other Name MEDICAL RECORD #_____
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ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

DAY PHONE: \_\_\_\_\_ EVENING PHONE: \_\_\_\_\_

Type of access requested:  Inspection  Hard Copy  Electronic Copy (only available if SSM Health Care maintains the requested information electronically)

I Hereby Authorize:

To Disclose My Protected Health Information To:

NAME	_____
ADDRESS	_____
CITY, STATE & ZIP	_____
PHONE	_____
FAX	_____

NAME	_____
Relationship	_____
ADDRESS	_____
CITY, STATE & ZIP	_____
PHONE	_____
FAX	_____

METHOD OF DELIVERY OF RECORDS (please select one):

- Mail       Hold for pick up by: \_\_\_\_\_  
 Electronic (records will be provided on a CD and mailed to your residence)

INFORMATION TO BE RELEASED:

DATES: \_\_\_\_\_

- Discharge Summary \_\_\_\_\_  
 History & Physical Exam \_\_\_\_\_  
 Progress Notes \_\_\_\_\_  
 Lab Reports \_\_\_\_\_  
 X-Ray Reports \_\_\_\_\_  
 Medication Records \_\_\_\_\_  
 Detailed Bill \_\_\_\_\_  
 Other (specify content and dates): \_\_\_\_\_

**I specifically authorize the release of information relating to:**

- Substance abuse (including alcohol/drug abuse)  
 Mental health or behavioral health  
 HIV related information (AIDS related testing)

X  
 SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE    DATE

**PURPOSE OF DISCLOSURE:**

- Changing physicians  Consultation  Insurance/Workers' Compensation  School  Research  At request of individual  
 Legal (specify): \_\_\_\_\_  
 Other (specify): \_\_\_\_\_  
 For personal access (specify):  Copy  Inspection  Summary

**ACKNOWLEDGEMENT OF UNDERSTANDING:**

- I understand the expiration date of this authorization is  \_\_\_\_\_  at end of research study;  not applicable for ongoing research.
- I understand that I may revoke this authorization at any time by notifying the providing organization in writing, and it will be effective on the date notified except to the extent action has already been taken in reliance upon it.
- I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by Federal or State privacy regulations.
- By authorizing this use or disclosure of information, there will be no conditions placed on my health care or payment for my health care.
- I understand that if I am being requested to authorize a use or disclosure that, upon request, I will get a copy of this form after I sign it.
- I understand my request will be acted upon within 30 days. If I am not provided access or information cannot be supplied, I understand I will be notified, and have the right to request review of any denial of access other than those made in accordance with applicable law.
- I understand that I may be required to pay the cost of creating paper copies or electronic media, mailing copies, supervising my inspection, or preparing a summary except for uses and disclosures for the purpose of treatment, payment, and operations.
- SSM Health Care believes that the only way to avoid third party interception of information sent through e-mail is to send such information by encrypted e-mail. Despite this warning about the risk that my protected health information could be read/intercepted by a third party if it is not sent by encrypted e-mail, I request SSM Health Care to send an electronic copy (if available) of the requested information by unencrypted e-mail.

I acknowledge and understand the terms of this **Request for Access to/Authorization for Use and Disclosure of Protected Health Information**.

Patient/Legal Representative Signature: \_\_\_\_\_ DATE: \_\_\_\_\_

Relationship: \_\_\_\_\_

Records Received by: \_\_\_\_\_ DATE: \_\_\_\_\_ ID VERIFIED: \_\_\_\_\_



PATIENT LABEL

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS