I, _____ **HEREBY AUTHORIZE** disclosure and/or inspection of PHI for:
Patient or Personal Representative Name

_____ _____ xxx - xx - _____ _____
Patient Name *DOB* *SSN (last four digits)* *Phone Number*

FROM THE FOLLOWING:

☐ St. Joseph Medical Center ☐ St. Anthony Hospital ☐ St. Clare Hospital ☐ St. Francis Hospital
☐ St. Elizabeth Hospital ☐ Harrison Medical Center ☐ Regional Hospital ☐ Highline Medical Center
☐ Franciscan Medical Group: _____
Clinic Name: _____ Provider Name: _____
☐ Harrison HealthPartners: _____
Clinic Name: _____ Provider Name: _____

PURPOSE OF DISCLOSURE:

☐ Attorney ☐ Insurance ☐ Provider ☐ Personal ☐ Other (specify) _____

DATES TO BE RELEASED
☐ Most recent two years
☐ Most recent five years
☐ All dates
☐ Specific dates for care received:
From ____ /____ /_____ Through ____ /____ /_____

INFORMATION TO BE RELEASED	
☐ Care Notes	☐ ED Records
☐ Immunization Records	☐ Discharge Summaries
☐ Lab Reports	☐ History and Physicals
☐ EKG Reports	☐ Consultations
☐ Pathology Reports	☐ Surgery/Procedure Reports
☐ Radiology Reports	☐ Films/Images
☐ Billing Records	☐ All Records
☐ Other (specific type) _____	

RELEASE INFORMATION TO:

Organization/Person: _____ Phone/Fax: _____

Address: _____ City: _____ ST:_____ Zip: _____

If requesting a copy of your own records, how would you like to receive this information? **Paper** ☐ **CD** ☐ **Pick-up** ☐

Electronic Delivery (see additional form required) ☐ **Email address:** _____

I AUTHORIZE _____ TO PICK UP THE ABOVE RECORDS.

Patient's Additional Authorization: I understand that my records may contain information regarding the diagnosis or treatment of HIV/AIDS, sexually transmitted diseases, drug and/or alcohol abuse, mental illness or psychiatric condition and genetic testing. You are specifically authorized to release all health care information relating to such diagnosis, testing or treatment unless specifically excluded (please check if you do **NOT** want this information released):

☐ HIV/Aids ☐ Sexually Transmitted Disease ☐ Alcohol/Drug Abuse or Treatment ☐ Mental Health ☐ Genetic Testing

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

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 Franciscan Health's** Notice of Privacy Practices.

EXPIRATION: This authorization will expire when the request has been filled, or on this date: _____

By signing this page, I acknowledge that I have read and agreed to the terms on both sides of this form.

Signature (Patient or Person Authorized to Give Authorization)	***Date:***	***Time:***
If signed by Person Other Than Patient, Provide Reason, Relationship to Patient, Description of Their Authority		

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(02/01/2019)

CHI Franciscan

AUTHORIZATION FOR USE OR DISCLOSURE
OF PROTECTED HEALTH INFORMATION (PHI)

Patient Information

Minors: A minor patient's signature is required in order to release the following information (1) conditions relating the minor's reproductive care (2) sexually transmitted diseases (if age 14 and older), (3) alcohol and/or drug abuse and mental health conditions (if age 13 and older).

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.

* If authorization is for *marketing,* indicate if **CHI Franciscan** will receive compensation in exchange for the use and/or disclosure of the PHI. ____ Yes or ____ No

Prohibition on Conditioning of Authorization: CHI Franciscan 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).

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

This authorization form may be sent to us by fax:

St. Joseph Medical Center, St. Clare, St. Francis, St. Elizabeth, St. Francis, St. Anthony Hospitals,
HIM Department
Fax: 253-426-6924
Phone: 253-426-6672
Email: fhsmedicalrecords@chifranciscan.org

Highline Medical Center, Regional Hospital
HIM Department
Fax: 206-241-6945
Phone: 206-431-5345
Email: fhsmedicalrecords@chifranciscan.org

Harrison Medical Center
HIM Department
Fax: 253-426-6924
Phone: 253-426-6672
Email: HIMROI@chifranciscan.org

Franciscan Medical Group (including Harrison Health Partners)
HIM Department
Fax: 253-792-4993
Phone: 253-792-2400
Email: fmgmedicalrecords@chifranciscan.org

Please visit https://www.chifranciscan.org/patients-and-visitors/medical-records.html to obtain the mailing address of the above facilities.

FACILITY STAFF USES:
Request Received By: ______________________________ Date: ______________________

COPY OF AUTHORIZATION PROVIDED: _____Yes _____No FEE SCHEDULE PROVIDED: _____Yes _____No
The Personal Representative presented the following documentation to demonstrate their authority to act on behalf of the patient:

_______Power of Attorney _______ Death Certificate _______Executorship _______Court Order

Authorized Personal Representative notified that records were ready on Date: __________________Employee Initials_______

Signature of person picking up records Date

Type of photo identification verified: ___ Driver's License ___ Military I. D. ___ Other _________________ Employee Initials _____

CHI Franciscan

Patient Information

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)