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

I, _____ hereby authorize _____
Print Name of Individual (i.e., patient, resident or client) Facility/Clinic

to use and disclose the protected health information as described below for the following patient:

Patient Name: _____ DOB: _____

Street Address: _____ Phone: _____

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:**
(Below are the most frequently requested documents. This does not constitute your entire medical record, which you have the right to request.*)

Check(✓) all that apply:

__ Abstract (Includes[1])
__ Discharge Summary /Final Diagnosis[1]
__ History and Physical Records[1]
__ Consultation Reports[1]
__ Operations and Procedures[1]
__ Results of Diagnostic Testing[1]
__ Emergency Room Records
__ Lab Reports
__ Radiology (for example: X-Ray) Reports
__ Other Diagnostic Reports
__ Diagnostic Images (Prepped by Radiology Dept)
__ Immunization (shot) Record
__ Physical Therapy Notes
__ Physician Notes
__ Medication List
__ Itemized Bill

__ Other*: _____



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CHI Franciscan

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

Patient Information

Dates of treatment to be released: From: _____ To: _____
Reason or purpose for the use, and/or disclosure of the information:
_____

I request the form of release of information be ___ Electronic (Portal) ___ Paper (U.S. Mail or pick up)
___ Other (USB, etc ... **)_____ ___ Electronic (Secure Email)
**Device must be provided by the facility

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.

**Prohibition on Conditioning of Authorization:** The healthcare provider 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 my 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 1 year from the date signed unless the facility receives a Revocation as outlined below.

**Revocation:** I understand that I may revoke this authorization at any time by notifying the facility 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 were taken before the revocation letter was received. I understand that the facility 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 Facility's Notice of Privacy Practices.

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

*If this authorization is for marketing by the covered entity, indicate if the covered entity will receive compensation for the use and disclosure of PHI. ___Yes ___No*

**SIGNATURE OF INDIVIDUAL OR PERSONAL REPRESENTATIVE** **DATE (Required)**

_____

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

_____

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

_____

(Please include supporting documentation such as Power of Attorney documents, or other documents)

**This authorization form may be sent to us by fax:**

**St. Joseph Medical Center, St. Clare, St. Francis, St. Elizabeth, St. Anthony Hospitals**
HIM Department
Fax: 253-426-6924
Phone: 253-426-6673
Email: fhsmedicalrecords@chifranciscan.org

**St. Michael Medical Center**
HIM Department
Fax: 253-426-6924
Phone: 253-426-6673
Email: HIMROI@chifranciscan.org

**St. Anne Hospital**
HIM Department
Fax: 253-426-6924
Phone: 253-426-6673
Email: fhsmedicalrecords@chifranciscan.org

**Franciscan Medical Group**
HIM Department
Fax: 253-792-4993
Phone: 253-792-2400
Email: fmgmedicalrecords@chifranciscan.org



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



(596065 06/18/20)