

SAINT CLARE'S HEALTH SYSTEM

For Office Use Only:
M.R.#
P.A.#

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

PATIENT NAME: _____ D.O.B.: _____

S.S.#: _____ TELEPHONE: _____

I hereby authorize the Health Information staff of Saint Clare's Health System to disclose my health information to:

The information to be disclosed to and used by the above is for the following purpose: _____

This authorization is limited to the following dates of treatment:

FROM _____ TO _____

Information to be disclosed:

- ABSTRACT** (Includes: Face sheet, Diagnosis, Discharge Summary, H&P, ER report, Consultations, Procedure reports and test results, as applicable.)
- DISCHARGE SUMMARY** **EMERGENCY ROOM** **LAB, X-RAYS & TESTS**
- OPERATIVE REPTS & PATHOLOGY** **COMPLETE RECORD**
- OTHER** _____

***Please inquire regarding fees for copies of medical records

I understand that the information to be disclosed includes my identity, diagnosis and treatment including ALCOHOL, DRUGS, GENETIC TESTING, BEHAVIORAL OR MENTAL HEALTH SERVICES, AIDS and HIV, TUBERCULOSIS, SEXUALLY TRANSMITTED and other INFECTIOUS DISEASE information, as applicable.

Please specify if any of the above types of information are to be excluded from this authorization and not released:

It is my intent that the use of the information furnished is prohibited for any purpose other than stated above and that the recipient is prohibited from disclosing this information to any other party to whom disclosure is not necessary or required for the purpose stated above.

I understand that I have the right to revoke this authorization at any time. I understand if I revoke this authorization, I must do so in writing and present my written revocation to the Health Information department. I understand that this revocation will not apply to the extent that Saint Clare's Health System has already taken action in reliance on this authorization. This authorization will automatically expire 120 days from the date of my signature, unless I otherwise specify that this authorization will terminate on the following date, or concurrently with the following event or condition: _____.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment, payment, enrollment or eligibility for benefits. I understand I may inspect or obtain a copy of the information to be used or disclosed, as provided in 42 CFR 164.524. I understand any disclosure of information carries with it the potential for an un-authorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact Health Information – Correspondence Area at (973) 989-3660.

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

PATIENT SIGNATURE: _____ DATE: _____

If legal representative, sign below and state relationship and authority to do so and attach the document of authority.

LEGAL REPRESENTATIVE: _____ DATE: _____

RELATIONSHIP: _____

WITNESS: _____ DATE: _____

