Saint Francis HEALTHCARE

Health Information Management
211 Saint Francis Drive
Cape Girardeau, MO 63703
P 573-331-5120
F 573-331-5015

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

Patient Identification

Name:_____Date of Birth:_____

Address:_____Phone #_____

I hereby authorize_____ to disclose the following information to:

_____or the following dates_____to_____.
(self, representative, healthcare. provider)

Release or Mail To:

Individual/Legal Guardian/personal Representative:_____

Street Address:_____

City, State and Zip Code:_____

Information to be released

Please check type of information to be released:

❑ Complete health record	❑ Emergency Department	❑ Discharge summary
❑ History and physical exam	❑ Consultation reports	❑ Operative reports
❑ Laboratory/pathology	❑ X-ray reports	❑ EKG
❑ Progress Notes	❑ X-ray films/images	❑ Billing records

❑ Other (specify)_____

Drug and/or Alcohol Abuse. and/or Psychiatric, and/or HIV/AIDS Records Release:

I DO NOT WANT THE FOLLOWING INFORMATION DISCLOSED:

Alcohol/drug abuse_____ HIV test results_____ Mental health records_____

Expiration of Authorization:

This Authorization shall remain in effect for ninety days unless sooner revoked in writing delivered to Saint Francis Medical Center.

Processing Your Requested Information:

Saint Francis Healthcare System may charge a fee for the copying of requested health information.

Your Rights under this Authorization:

I understand that I am entitled to a copy of the signed Authorization and that I can inspect or copy the protected health information to be used or disclosed. I understand that I may be charged a copying fee. I understand that I may revoke this Authorization at any time except to the extent that prior action has been taken in reliance on this Authorization. I understand that if I want to cancel/revoke this Authorization, I must mail or fax a letter to Saint Francis Medical Center stating that I want to cancel this Authorization. I understand the information disclosed by this Authorization may be subject to re-disclosure by the recipient and no longer be protected by the Health Insurance Portability and Accountability Act of 1996. The facility, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Signature of Patient or Personal Representative Who May Request Disclosure:

I understand that I do not have to sign this Authorization and my treatment or payment for services will not be denied if I do not sign this form.

Signature of Patient or Legal Representative_____Date:_____

Authority to sign if not patient_____