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 Name: _____ **Date of Birth** _____

Address: _____ **Phone:** _____

I authorize disclosure of the above named patient's health information: _____.
(Self, name of relative, name of physician, name of law firm, etc.)

Please check the release method:

☐ MyChart ☐ Email to _____ ☐ Fax to _____
☐ Mail paper records to the following address: _____
☐ Mail CD to the following address: _____

Date range of health information to be released:
☐ All Dates ☐ Only the following dates: _____ to _____

Health information should be released for the following practice / location:
☐ Saint Francis Medical Center-Hospital/Main Campus Only ☐ Other (see back) _____

Please check type of information to be released:

☐ Complete health record
☐ History and physical exam
☐ Laboratory/Pathology
☐ Progress Notes
☐ Office Notes
☐ Emergency Department
☐ Consultation reports
☐ X-ray reports
☐ X-ray films/image
☐ Discharge summary
☐ Operative reports
☐ EKG
☐ Immunizations
☐ Billing records

Other (specify) _____

Drug and/or Alcohol Abuse, and/or Psychiatric, and/or HIV/AIDS Records Release, Genetic Testing:
I DO NOT WANT THE FOLLOWING INFORMATION DISCLOSED:
☐ Alcohol/Drug Abuse ☐ HIV/STD test results ☐ Mental Health Records ☐ Genetic Testing Results

Expiration of Authorization:
This Authorization shall remain in effect for ninety days unless sooner revoked in writing delivered to Saint Francis Healthcare System.

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 Healthcare System 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: _____

Saint Francis
HEALTHCARE

Please check the location from which you would like your medical records:

- ☐ Saint Francis Medical Center—Hospital/MainCampus
- ☐ Advanced Orthopedic Specialists/HandCenter
- ☐ Black River Medical Center*through 08/12/2019
- ☐ Cape Cardiology Group
- ☐ Cape Care forWomen
- ☐ Cape Diabetes andEndocrinology
- ☐ Cape ENT Group
- ☐ Cape Gastroenterology Specialists
- ☐ Cape Gynecologic Oncology
- ☐ Cape Medical Oncology
- ☐ Cape Neonatology Specialists
- ☐ Cape Neurology Specialists/ConcussionClinic
- ☐ Cape Neurosurgical Associates
- ☐ Cape Occupational Medicine
- ☐ Cape Pain Management
- ☐ Cape Physician Associates
- ☐ Cape Primary Care/Immediate ConvenientCare
- ☐ Cape Pulmonology and SleepMedicine
- ☐ Cape Radiation Oncology
- ☐ Cape Spine and Neurosurgery/Heartland Spine Institute
- ☐ Cape Thoracic and CardiovascularSurgery
- ☐ Charleston Family Care
- ☐ Farmington Physician Associates
- ☐ Ferguson Medical Group
- ☐ Infectious Disease/Specialty Clinic
- ☐ Jackson Family Care/Immediate Convenient Care Jackson
- ☐ Jackson Physician Associates
- ☐ Kneibert Clinic
- ☐ Physicians' Park PrimaryCare
- ☐ Physicians' Park General Surgery
- ☐ Piedmont Physician Associates
- ☐ Poplar Bluff Neurology
- ☐ Poplar Bluff Pediatrics
- ☐ Saint Francis HealthCenter--Dexter
- ☐ Saint Francis HealthCenter—Poplar Bluff
- ☐ Saint Francis Outpatient Rehabilitation
- ☐ Sikeston Imaging Center
- ☐ Sikeston Neurology
- ☐ Weight Loss Solutions
- ☐ Womancare
- ☐ Wound Healing and HyperbaricCenter