

Patient Authorization to Disclose Protected Health Information (PHI) *St. Vincent Hospital has 10 business days to complete the this request.

| | | |
|----------------------|-----------------------|------------------------------|
| Patient's Full Name: | Date of Birth | Last 4 of Social Security #: |
| Street Address: | City, State, Zip Code | Telephone #: |
| E-mail Address: | | |

I hereby authorize the facility listed below to disclose/release the Protected Health Information specified in this request to the organization, agency or patient named.

| | |
|-----------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Release By: | Release To: |
| Facility Name | Facility Name |
| Address | Address |
| City, State, Zip Code | City, State, Zip Code |
| HIM Phone #: | HIM Phone #: |
| Fax #: | Fax #: |
| Treatment Date(s): _____ - _____ | Type of Disclosure Authorized & Delivery Instructions: Provide Copies of records to Organization/Agency/ Individual listed above. Mail records directly to address above Call to pick-up records: _____ Fax records to: _____ |
| Purpose: | |
| Further Medical Care Worker's Comp Personal Use | |
| Insurance Legal Marketing/ Fundraising | |
| Other: _____ | |

Pertinent Protected Health Information (PHI) Authorized to be included:

| | | | | | |
|-------------------|------------------------|------------------|------------------------|---------------|--------------------|
| Discharge Summary | Radiology | Special Studies | H & P (s) | Consult | Out PT Record(s) |
| RX Record(s) | Op Report(s) | Progress Note(s) | Psych Health Record(s) | Lab Result(s) | Physician Order(s) |
| Medial Record | Other (Specify): _____ | | | | |

***Psychotherapy Notes are distinct and may not be included with the disclosure of any other protected health information. A Patient Authorization to Disclose Psychotherapy Notes must be completed.**

Authorization: I certify that this request is made voluntarily and that the information given above is accurate to the best of my knowledge. I understand that I may revoke this authorization at any time in writing by submitting my request in writing to the designated Health Information Management I Medical Records department. If I have authorized the disclosure of my health information to someone who is not legally required to keep it private, it may be re-disclosed and may no longer be protected. A copy or fax of this authorization will be as valid as the original.

I understand that authorizing disclosure of health information is voluntary. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment, or my eligibility to obtain benefits. I understand that I may inspect or obtain a copy of the information to be disclosed. I understand a fee may be charged for copies of my medical record. I understand the facility will provide me a copy of the signed authorization form. If I have questions about disclosure of my health information, I can contact the designated Corporate Responsibility and Privacy Officer.

Expiration: Without my express revocation, this authorization will automatically expire upon satisfaction of the need for disclosure, but in any event will expire 90 days from the date hereof, unless a different date is specified here:

Acknowledgement: I understand that the information to be disclosed may include any or all information involving communicable or venereal disease, psychological or psychiatric conditions, drug or alcohol abuse and/or alcoholism. It may also include, but is not limited to, diseases such as hepatitis, syphilis, gonorrhea and human immunodeficiency viruses (HIV), also known as acquired immune deficiency syndrome (AIDS).

For Marketing/Fundraising Purposes Only, if applicable: I understand that St. Vincent General Hospital District (SVGHD): will will not receive remuneration, either direct or indirect, as a result of the marketing that I hereby authorize.

Signature of Patient / Parent - Legal Representative: _____ Date/Time: _____ / _____

If Legal Representative, Print Name: _____ Relationship to Patient: _____

Minor's signature is required for release of any records for treatment which the minor may authorize under Colorado Law.

SVGHD Use Only Request Received By: _____ Date Received: _____

Medical Record #: _____ Identity Verification (DL# / Other ID#): _____

Date Completed: _____ / _____ / _____ Completed By: _____