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Consent

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

I (the undersigned) hereby authorize the St. Vincent Facility(ies) indicated below to disclose/obtain the following identified information. Please check all that apply:

☐ St. Vincent Clay ☐ St. Vincent Dunn ☐ St. Vincent Frankfort ☐ St. Vincent Jennings
☐ St. Vincent Mercy ☐ St. Vincent Randolph ☐ St. Vincent Salem ☐ St. Vincent Williamsport

PATIENT VISIT INFORMATION **NOTE: ITEMS WITH * ARE REQUIRED FIELDS.**

***Name of Patient**	***Date of Birth**
Other Names used during treatment (if applicable)	Social Security Number
***Dates of Treatment Requested**	***Purpose of Disclosure**

RELEASE INFORMATION TO:

Name (if not patient)	
***Address**	***Phone number**
***City, State, Zip Code**	

INFORMATION TO BE RELEASED (limit request to the minimum necessary)

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	Admission/Registration Record		Operative/Procedure Report		Physical Therapy
	Discharge Summary		Consultation		Pathology Report
	ER Report		Short Stay Note		Progress Notes
	History & Physical Report		Nurses Notes		X-Ray Report
	Mammogram Films		Physician Orders		EKG
	MRI Films		Lab		EEG
	CT Films		Respiratory		Stress Test
	OTHER: Please Specify				

- I understand that the Protected Health Information in my medical record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.
- I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the address below. I understand that a revocation is not effective to the extent that St. Vincent has relied on the use of disclosure of the protected health information. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.
- I understand that this authorization will expire in sixty (60) days unless otherwise specified here_____.
- I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.
- St. Vincent will not condition my treatment, payment, enrollment (if applicable) in a health plan or eligibility for benefits on whether I provide authorization for the requested use or disclosure.
- I understand that I have the right to refuse to sign this authorization.
- By signing this authorization, I acknowledge that I have read and understand this authorization. Further, I authorize the use or disclosure of my Protected Health Information in accordance with the terms of this authorization.

***Signature of Patient, Guardian, Parent, or Health Representative**	***Date Signed**
Relationship to patient (if other than self or your minor child we will require proof of authority to act on behalf of patient)	

I understand that I am responsible for paying the applicable fees , if any.
I have the right to an estimate of the fees before receiving a copy of the records.

☐ **ID checked** **HIM associate**_____ **Date** _____

# of Pages	COPIES WERE: ☐ Mailed to requester ☐ Picked Up ☐ Faxed	Date Sent/ Picked up/Faxed	Associate Witness:

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