CHRISTUS ST. VINCENT Health System

Authorization for Use and Disclosure of Protected Health Information

Patient Identification

Printed Name:_____ Date of Birth:_____

Address:_____

Telephone: (_____)_____

Information to be Released – Covering the Periods of Health Care

From (date)_____ To (date)_____

Please check type of information to be released:

☐ Complete health record	☐ Diagnosis & treatment codes	☐ Discharge summary
☐ History and physical exam	☐ Consultation reports	☐ Progress notes
☐ Laboratory test results	☐ Radiology reports/images	☐ Cardiac imaging
☐ Photographs, videotapes	☐ Complete billing record	☐ Itemized bill
☐ Discharge Instructions	☐ Pulmonary function results	☐ Immunization Record
☐ Release Of Information (ROI) Abstract – History &Physical (H&P), Discharge Summary, Labor & Delivery Note, Operative Report, Procedure Note, Consultation, Laboratory, Pathology, X-ray reports.		

☐ Other (specify)_____

Purpose of Request

☐ Treatment or consultation	☐ At the request of the patient	☐ Billing or claims payment

☐ Other (specify)_____

Send/Release Information: ☐ **Hospital Records** ☐ **Records from Clinic Name/Provider** _____

☐ **Paper** ☐ **CD** (if available) ☐ **Electronic Portal** (E-mail notification when access is available) ☐ **E-mail**

Unencrypted electronic transmissions are not secure. Although it is unlikely, there is a possibility that information in an unencrypted electronic transmission can be intercepted and read by other parties besides the person to whom it is addressed. ***Please initial if you have requested your information to be sent to you in an unencrypted electronic format. _____.**

Release to Name:_____

Mail to Name:_____

Mail to Address:_____

E-mail Address:_____

Substance Use Disorder, and/or Psychotherapy, and/or HIV/AIDS Records Release

I understand that if my medical or billing records contain information in reference to substance use disorder and/or psychotherapy treatment I have been afforded the opportunity to sign a specific authorization. ***Initial One:*** ***Yes*****_____** **No_____** **Not Applicable _____**

I understand if my medical or billing records contain information in reference to HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome) testing and/or treatment I have been afforded the opportunity to sign a specific authorization.

Initial One: **Yes _____ No _____ Not Applicable _____**

Time Limit & Right to Revoke Authorization

Except to the extent that action has already been taken in reliance on this authorization, at any time I can revoke this authorization by submitting a notice in writing via email to the facility Privacy Officer at CSV-ComplianceOfficer@stvin.org Unless revoked, this authorization will expire on the following date or event _____or 180 days from the date of signature.

Re-disclosure

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 or Legally Authorized 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 unless specified above under Purpose of Request. I can inspect or copy the protected health information to be used or disclosed.

I authorize CHRISTUS St. Vincent Health System to release the protected health information specified above.

Signature:_____ Date:_____

Authority to Sign if not Patient:_____

Identity of Requestor Verified via: ☐ **Photo ID** ☐ **Matching Signature** ☐ **Other, specify** ☐_____

Verified by:_____