Authorization for Use and Disclosure of Protected Health Information

Print Patient Last Name ______ First ______ Middle ______
Address ______ City ______ Stat ______ Zip ______
Social Security Number ______ Date of Birth ______ Phone ______
I authorize St. Joseph Medical Center to disclose protected health information to:
Name ______ Phone/Fax Number ______
Address ______ City ______ State ______ Zip ______
☐ Call this phone number when records are available for pick up at hospital ______

PURPOSE FOR USE/DISCLOSURE ______
Approximate date(s) of service to be used/disclosed: ______
INFORMATION TO BE USED / DISCLOSED

- ☐ Emergency Room Record
- ☐ Discharge summary
- ☐ History and Physical
- ☐ Operative/procedure report
- ☐ Consultation report(s)
- ☐ Other ______
- ☐ Pathology report
- ☐ Lab reports
- ☐ Radiology reports/films
- ☐ EKG report(s)

Specific Authorization to Disclose Sensitive Records I UNDERSTAND THAT THIS AUTHORIZATION IS TO INCLUDE USE / DISCLOSURE OF: (please check and initial)

- ☐ Alcohol and/or drug abuse records *Initials* ______
- ☐ Sexually transmitted disease information *Initials* ______
- ☐ Psychiatric records *Initials* ______
- ☐ HIV/AIDS information *Initials* ______

*This information is disclosed from records whose confidentiality is protected by federal law. Federal regulations prohibit you from making any further disclosure of this information without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization is NOT sufficient for this purpose.

- I understand that I may revoke this authorization, in writing, at any time except to the extent that St. Joseph Medical Center has already relied on this authorization.
- I understand that I may revoke this authorization by sending or faxing a written notice to the Privacy Officer, at St. Joseph Medical Center, 1401 St. Joseph Parkway, Houston, TX 77002 or fax 713-756-8526, stating my intent to revoke this authorization.
- Unless otherwise revoked, I understand that the specific date or event upon which this authorization expires is one year after signing and dating this form, unless otherwise documented here: ______
- I understand that St. Joseph Medical Center may not condition treatment, payment, enrollment or eligibility for benefits on the completion of this authorization form.
- I understand that information being disclosed may be subject to re-disclosure by the recipient and may no longer be "covered entity" protected by the Federal privacy law, if the recipient is not.

☐ If box is checked, the hospital will receive direct or indirect financial compensation in connection with the use or disclosure of your information for marketing purposes.

______ Signature (Patient or Patient's Legal Representative) ______ Date

______ Printed Name of Legal Representative ______ Relationship to Patient

PLEASE NOTE: THIS FORM MUST BE COMPLETED IN ITS ENTIRETY. THANK YOU FOR YOUR COMPLIANCE.

Account Number: MR Number:
Patient Name:
Admit Date:

DOB	Age	Sex	HT	WT	RM-BD	PT	Svc	FC

Allergies:
Attending Physician Name: