Steward
Steward Health Care System

Authorization to Use and/or Disclose Protected Health Information

☐Request Completed by ____________ (staff initial) Medical Record # ______________________

I hereby authorize Sebastian River Medical Center to use and/or disclose the Protected Health Information specified below from my medical records.

1) Patient Name: (Please Print) ____ Date of Birth: ________________

Address: ____
Street City State Zip

Contact Telephone Number(s) ____

2) Information to be Disclosed To:

____
Person or Facility Name (Please Print)

____
Address (Please Print) City State Zip

Fax # ____________________

Phone #__________________

3) Treatment Dates: From: ____________________ To: ______________________
4) Specific Records/Report(s) to be Released:

☐Admission History and Physical
☐Discharge Summary
☐Emergency Room
☐EKG Reports
☐Laboratory Results
☐Imaging Reports (CT, X-Ray, MRI)
☐Pathology Reports
☐Operative Notes
☐Rehab Services (PT, OT, Speech)
☐Other
____
____

5) Restricted Release: We will **not** disclose the following documentation **unless** you check the box and provide an additional signature:

Release	Signature	Release	Signature
☐Mental/Behavioral Health Provider Documentation*		☐Genetic Testing/Test Results**	
☐HIV/AIDS Screening Test Results		☐Alcohol*** and/or ☐Substance Abuse Treatment***	
☐Confidential Communication with a Social Worker		☐Child/Elder Abuse and Neglect	
☐Rape/Sexual Assault Victim's Counseling		☐Domestic Violence Victim's Counseling	
☐Sexually Transmitted Disease			

* This authorization is not valid for use or disclosure of psychotherapy notes
** The term "genetic tests" means only those tests which determine your future chances of developing a disease, not tests done to diagnose a current condition or problem
*** Only applicable to records that are created by an "individual or entity who holds itself out as providing alcohol or drug abuse diagnosis, treatment, or referral for treatment." (42 CFR Part 2) Does not include records created or maintained by a general medical facility.

6) Exclusion Request:
I request that the following admission(s)/visit(s) be specifically excluded from this request ____________________________ (specify dates of service)

7) Purpose of the Disclosure:

☐Medical Care ☐Legal ☐Insurance ☐Personal ☐Other: ________________________

8) Term: This Authorization will remain in effect for one year or:

☐Until Sebastian River Medical Center fulfills this request

☐From the date of this authorization until the ______________________ day of ____________________ 20_______________

☐Until the following event occurs: ____

☐Other: ____

9) Revocation: I understand that I may revoke this Authorization at any time by requesting it of Sebastian River Medical Center in writing at the address listed below. The revocation will be effective immediately upon Sebastian River Medical Center's receipt of my written notice. I understand that the revocation will not have any effect on any action taken by Sebastian River Medical Center reliance on this Authorization before it received my written notice of revocation.

Attention Health Information Management
13695 US Hwy 1.
Sebastian, FL, 32958

10) Effect on Treatment: I understand that I may refuse to sign this Authorization for any reason and that such refusal will not affect the commencement, continuation, or quality of my treatment at Sebastian River Medical Center.
11) Potential for Redisclosure: I understand that the person receiving my Protected Health Information may not be required to comply with federal and state privacy laws, and my Protected Health Information may no longer be protected by the applicable state and federal law once it is disclosed by Sebastian River Medical Center.
12) Access: I understand that in certain circumstances Sebastian River Medical Center has the right to deny me access to all or portions of my Protected Health Information Sebastian River Medical Center will notify me in writing of any such denials.

I have read and understand the terms of this Authorization and I have had an opportunity to ask questions about the user and/or disclosure of my health information. By my signature below, I hereby, knowingly and voluntarily, authorize Sebastian River Medical Center to user and/or disclose my health information in the manner described above.

13) ____ ________________________

Signature of Patient Date

____

Printed Name of Patient Witness

For Office Use:
☐ I.D. Verification _______________

Authorized patient representative signature. If the patient is a minor or is otherwise unable to sign this Authorization:

14) ____ ________________________

Signature of Personal Representative Date

____ ______________________________________

Printed name of Patient Representative Relationship to patient or authority to act for patient

Questions about the release should be directed to the hospital HIM Director.

For Office Use:

☐ Copy of this authorization provided to the patient

☐ Copy of this authorization provided to the personal representative