



**Request for Access to/Authorization for Use and Disclosure of Protected Health Information**

PATIENT NAME: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_  
LAST - - - FIRST MI Maiden or Other Name  
MO DAY YR FORMER NAME: \_\_\_\_\_ SOCIAL SECURITY # \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

DAY PHONE: \_\_\_\_\_ EVENING PHONE: \_\_\_\_\_

**I hereby authorize  St. Francis Family Health Care /  \_\_\_\_\_ to disclose my protected health information as indicated below to:**

Mail to:  Hold for pick up by: \_\_\_\_\_  Fax via confidential fax machine (treatment purposes only):

NAME: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

PHONE: \_\_\_\_\_ FAX: \_\_\_\_\_

**INFORMATION TO BE RELEASED:**

**DATES OF SERVICE** \_\_\_\_\_

- Discharge Summary
- History & Physical Exam
- Progress Notes
- Lab Reports
- X-Ray Reports
- Operative Report
- Emergency Room Record
- Other (specify content): \_\_\_\_\_
- EKG Reports
- Echocardiogram
- Holter Monitor Reports

**I specifically authorize the release of information relating to:**

- Substance abuse (including alcohol/drug abuse)
- Mental health or behavioral health
- HIV related information (AIDS related testing)

X \_\_\_\_\_

**SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE**

**PURPOSE OF DISCLOSURE:**

- Changing physicians
- Legal (specify): \_\_\_\_\_
- Other (specify): \_\_\_\_\_
- For personal access (specify):  Copy  Inspection  Summary
- Consultation
- Insurance/Workers' Compensation
- School
- Research
- At request of individual

**ACKNOWLEDGEMENT OF UNDERSTANDING:**

I understand the expiration date of this authorization is 90 days from the date of this request unless otherwise authorized here  
 \_\_\_\_\_  at end of research study;  not applicable for ongoing research.

I understand that I may revoke this authorization at any time by notifying the providing organization in writing, and it will be effective on the date notified except to the extent action has already been taken in reliance upon it.

I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by Federal privacy regulations.

By authorizing this use or disclosure of information, there will be no conditions placed on my health care or payment for my health care.

I understand that if I am being requested to authorize a use or disclosure that I will get a copy of this form after I sign it.

I understand my request will be acted upon within 30 days. If I am not provided access or information cannot be supplied, I understand I will be notified, and have the right to request review of any denial of access other than those made in accordance with applicable law.

I understand that I may be required to pay the cost of preparing and mailing copies, supervising my inspection, or preparing a summary except for uses and disclosures for the purpose of treatment, payment, and operations.

**Patient/Legal Representative Signature:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

Relationship: \_\_\_\_\_ Witness \_\_\_\_\_

Records Received by: \_\_\_\_\_ **DATE:** \_\_\_\_\_ **ID VERIFIED:** \_\_\_\_\_



St. Francis Family Health Care  
**St. Francis Hardin Medical Clinic**  
**West Nodaway Health Clinic**