St. Francis
Hospital & Health Services

2016 South Main – Maryville, MO 64468
Phone 660-562-2600 FAX 660-562-7960

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

PATIENT NAME:____
LAST FIRST MI Maiden or Other Name
DATE OF BIRTH:_____-_____-_____ FORMER NAME:________________________SOCIAL SECURITY #________________________
MO DAY YR
ADDRESS:____ CITY:_____________________STATE:____ZIP:_______________

DAY PHONE:________________________ EVENING PHONE:____________________________

I hereby authorize ❑St. Francis Hospital & Health Services / ❑_______________________________________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**): ❑ Send with patient to:

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
❑ Initial Evaluation
❑ Discharge Plan/Instructions
❑ 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

❑ Other (specify content):____

PURPOSE OF DISCLOSURE:

❑ Changing physicians ❑ Consultation ❑ Continuity of Care ❑ Insurance/Workers' Compensation ❑ School ❑ Research
❑ Legal (specify): ____
❑ Other (specify): ____
❑ For personal access (specify): ❑ Copy ❑ Inspection ❑ Summary

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____

Identity of requestor verified by________________ ❑Photo ID ❑Matching signature ❑Other, Specify______________________________

Signature of person receiving record (if other than the patient)____DATE:________________________
Identity of person receiving records verified by________________ ❑Photo ID ❑Matching signature ❑Other, Specify______________________

Request completed by:______________________________ Date_______________