AUTHORIZATION: PRIVILEGED USE / DISCLOSURE OF PHI

MR# ____________________

Acct# ____________________

Organization authorized to make disclosure:

- ☐ St. Francis Bradley Center
- ☐ St. Francis Cardiovascular and Thoracic Institute
- ☐ St. Francis Center for Digestive Disorders
- ☐ St. Francis Center for Surgical Care
- ☐ St. Francis Columbus Clinic
- ☐ St. Francis Continuity Clinic
- ☐ St. Francis Electrophysiology
- ☐ St. Francis ENT
- ☐ St. Francis Hospital
- ☐ St. Francis Interventional Pain Management
- ☐ St. Francis Neurology
- ☐ St. Francis OBGYN Associates
- ☐ St. Francis OBGYN Physician & Partners
- ☐ St. Francis OBGYN River Road
- ☐ St. Francis Orthopaedic Institute
- ☐ St. Francis Spine Center
- ☐ St. Francis Urology

***Please complete the following section** (print clearly)*

Patient's Last Name, ____ First Name, ____ MI ____

Birth Date *(Month/Day/Year)* ____

Street Address / Apt # *(Include Complete Mailing Address)* ____

Social Security Number ____

City ____ State ____ Zip ____

Home Phone # ____ Alternate Phone # ____

RELEASE INFORMATION TO *(Recipient of Use / Disclosure)*:

Name of Person or Organization Receiving Information ____

Telephone # ____

Street Address / Apt # *(Include Complete Mailing Address)* ____

Delivery Method:
- ☐ Pick up
- ☐ Mail
- ☐ CD / DVD
- ☐ Patient Portal *(email address must be provided)*

City ____ State ____ Zip ____

Email: ____________________

Requested date(s): ***From*** ____________________ ***To*** ____________________

Specific description of information to be used/disclosed:

- ☐ History and Physical
- ☐ All Diagnostic Report(s)
- ☐ Consultation Report(s)
- ☐ Radiology Report(s)
- ☐ Laboratory Report(s)
- ☐ Pathology Report(s)
- ☐ Discharge Summary
- ☐ Progress Notes
- ☐ Office Notes
- ☐ Summary / Abstract
- ☐ Complete Medical Record
- ☐ Other, specify ____________________

I understand that this will include information relating to (check if applicable):

- ☐ Acquired immunodeficiency syndrome (AIDS) human immunodeficiency virus (HIV) infection
- ☐ Behavioral health service / psychiatric care
- ☐ Treatment for alcohol and/or drug abuse

This information is to be used for the following purposes: (check all that apply)

- ☐ Legal Issue
- ☐ Insurance Claim
- ☐ Continuation of Care
- ☐ Personal Use
- ☐ Other, explain: ____________________

I understand that the information used/disclosed pursuant to this authorization may be subject to redisclosure by the recipient of the information and, depending upon the applicability of federal privacy regulations, may then no longer be protected by those federal regulations. I understand that I may revoke this authorization in writing at any time by sending the revocation to the Release of information Office at St. Francis Hospital, Inc., except to the extent that St. Francis Hospital, Inc. has taken action in reliance on this authorization. I understand that I may refuse to sign this authorization and if I do, my information will not be used or disclosed for the purposes stated above. I understand that treatment provided by St. Francis Hospital, Inc. will not be conditioned upon my signature on this authorization. Unless otherwise revoked, this authorization will expire ninety (90) days from today's date and no further use/disclosure as described above may be made after such expiration.

____________________ **Signature of Patient**

____________________ **Signature of Authorized Personal Representative**

____________________ **Date**

____________________ **Print Name of Authorized Personal Representative**

____________________ **Relationship to Patient**

Authorization for Disclosure of Health Information