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
- ☐ Radiology Report(s)
- ☐ Discharge Summary
- ☐ Summary / Abstract
- ☐ All Diagnostic Report(s)
- ☐ Laboratory Report(s)
- ☐ Progress Notes
- ☐ Complete Medical Record
- ☐ Consultation Report(s)
- ☐ Pathology Report(s)
- ☐ Office Notes
- ☐ 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
- ☐ Continuation of Care
- ☐ Other, explain: _____
- ☐ Insurance Claim
- ☐ Personal Use

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 _____

St.Francis
EMORY HEALTHCARE

Authorization for Disclosure of Health Information