ST. JOSEPH MERCY OAKLAND
SAINT JOSEPH MERCY HEALTH SYSTEM

Authorization for Use and Disclosure of Protected Health Information

Patient Identification

Printed Name: _____ **Date of Birth:** _____

Address: _____

City _____ **State** _____ **Zip** _____ **Telephone:** _____

Information To Be Released – Covering the Periods of Health Care

Facility Name: _____

Dates of Service: _____

Please check type of information to be released:

- ☐ **Summary of visit**
- ☐ **History and physical exam**
- ☐ **Laboratory test results/reports**
- ☐ **Operative reports**
- ☐ **Emergency department record**
- ☐ **Pathology reports**
- ☐ **Consultation reports**
- ☐ **Radiology reports**
- ☐ **Radiology Images**
- ☐ **Cardiology**
- ☐ **Discharge summary**
- ☐ **Progress notes**
- ☐ **Entire medical record**

Other: (specify) _____

Purpose of Request

☐ **Treatment or consultation** ☐ **At the request of the patient** ☐ **Billing or claims payment**

Person Authorized to Receive Information

Printed Name: _____ **Phone Number:** _____ **Fax Number:** _____

Address: _____

This authorization includes alcohol and drug abuse records protected under the regulations in Code 42 of Federal Regulations, Part 2, if any psychological services records, if any social services records, if any; psychiatric records, if any; records of Human Immunodeficiency Virus (HIV) testing including results, if any; records of treatment for Acquired Immunodeficiency Syndrome (AIDS), ARC (AIDS Related Complex), if any; and records of communicable disease, if any; to the individuals or organizations and for the conditions listed above.

This Authorization may be revoked if written revocation is received prior to information release. This Authorization will expire 180 days from Date of Signing or upon completion of the request. This authorization is only valid for treatment given prior to the date of signature.

Re-disclosure

I understand the information disclosed by this authorization may be subject to re-disclosure by the recipient and will no longer be protected by the Health Insurance Portability and Accountability Act of 1996. SJMO, its employees, officers, and physicians are hereby released from any legal responsibility of liability for disclosure of the above information to the extent indicated and authorized herein.

Signature of Patient or Personal Representative Who May Request Disclosure

I can inspect or request a copy of the protected health information to be used or disclosed. **I authorize SJMO to use and disclose the protected health information specified above.**

Authority to Sign if not the Patient: _____ Date: _____ Time: _____

Identity of Requester Verified via: ☐ **Photo ID** ☐ **Matching Signature** ☐ **Other: (specify)** _____

Signature: _____ Date: _____ Time: _____

Email Address: _____

Records Released & Witnessed by: _____ (Initials) **Delivery Method:** ☐ Email ☐ Mail