St. Francis Medical Group

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IMPORTANT-PLEASE READ
Transfer or Patient Personal Use – No retrieval fee.
$1.00/pg. (1-10), $0.50/pg (11-50), $0.25/pg (51+), Maximum $25
Plus actual postage.
Other - $20 retrieval fee (pages 1-10)
$0.50 each add'l pg. (11-50)
$0.25/pg. (51+), plus actual postage cost.
$10 add'l for two –day delivery.
$20 for record certification

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

PHI WILL BE USED OR DISCLOSED BY (Name and address of organization):

_____

_____

PHI WILL BE DISCLOSED TO (Name and address of organization):

_____

_____

Purpose for which disclosure is to be made (required): ☐ Personal Use ☐ Changing physicians ☐ Insurance

☐ Attorney ☐ Other _____

The PHI of:

Patient Name: _____
Last First Middle/Maiden

Address: _____
Street City State Zip

Date of Birth: _____ Social Security # _____ Phone # _____

Information to be disclosed (check items that apply):
☐ All Records (with exception of those requiring special consent) ☐ Abstract of Health Information ☐ X-Ray Reports

☐ Lab Reports ☐ Immunization Records ☐ Other (specify): _____

Date Range of Records Requested: _____

DISCLOSURES REQUIRING SPECIAL CONSENT (The following must be marked individually):
☐ HIV/AIDS ☐ Communicable Disease Records ☐ Mental Health Records

☐ Drug and Alcohol Treatment Records* - Dates Requested _____

I authorize the above named physician practice to release my PHI as described above and I understand the following:

1. To stop this Authorization, I must write a letter to the appropriate St. Francis Medical Group practice. Stopping the Authorization will not apply to information that was already sent out in response to the Authorization.
2. This Authorization will expire 60 days (180 days for Mental Health Records) from the date signed or the earlier date or event specified: _____
3. Information used or disclosed may be disclosed again by the person or organization that received it and no longer protected by Federal Privacy Rules. Note exception below for Drug & Alcohol Treatment Records.
4. Treatment cannot be denied for refusing to sign this Authorization, unless the service requested was for the purpose of creating PHI for a third party.

Date: _____ Signature: _____
Patient/Personal Representative

Description of Personal Representatives authority to act for the patient: _____

Witness Printed Name: _____ Witness Signature: _____

as * This information has been disclosed to you from records protected by Federal Confidentiality Rules (42 CFR Part 2). These Federal Rules prohibit you from making any further disclosure of this information, unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for release of medical or other information is NOT sufficient for this purpose. The Federal Rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.