



# St. Francis Medical Group

4770 S. Emerson Avenue, Suite A  
Indianapolis, IN 46203  
Phone: (317) 783-8009  
Fax: (317) 783-8012

### 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:

- 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.
- This Authorization will expire 60 days (180 days for Mental Health Records) from the date signed or the earlier date or event specified: \_\_\_\_\_
- 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.
- 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.