Saint Vincent Hospital

Authorization to Use and Disclose Protected Health Information

Authorization and request is hereby made to *(name of facility)*:

☐ Saint Vincent Hospital ☐ Other: _____

Information regarding: *(name of patient)* *(date of birth)* *(phone number)*

Request is being made for information regarding dates of service on:

By applying a check next to a category of highly confidential information listed below, I specifically authorize the use and/or disclosure of the type of highly confidential information, if any such information will be used or disclosed pursuant to this authorization.

☐ Mental Illness
☐ Psychotherapy Notes
☐ Venereal Disease
☐ HIV/AIDS Testing or Treatment (regardless of result)
☐ Sexual Assault
☐ Child Abuse or Neglect
☐ Drug & Alcohol Abuse
☐ Other *(specify)*: _____

The purpose of this information is for:

☐ Continuing Medical Care ☐ Personal Use ☐ Attorney/Legal Case ☐ Pre-employment
☐ Disability/Insurance Application or Claim ☐ Other *(specify)*: _____

Recipient *(name of person or class of persons to whom Saint Vincent Hospital may disclose my information)*

Address *(address of the recipient or where my health information should be delivered)*

The following information is requested:

☐ Abstract
☐ Face Sheet
☐ Discharge Summary
☐ History & Physical
☐ Progress Notes (physician)
☐ Progress Notes (nurse)
☐ Operative Report
☐ Pathology Report
☐ Medication Record
☐ E.R. Records
☐ Consult
☐ Patient Portal Code

DIAGNOSTIC TESTING
☐ Laboratory
☐ X-Ray
☐ EKG - Echocardiogram, Holter Monitor
☐ EEG

☐ Other (*specify*): _____

Term that this authorization will remain in effect:

☐ From the date of this authorization until the _____ day of _____ 201_____.

☐ Until Saint Vincent Hospital fulfills this request.

☐ Until the following event occurs: _____

☐ Other *(specify)*: _____

I understand that once Saint Vincent Hospital discloses my health information to the recipient, Saint Vincent Hospital cannot guarantee that the recipient will not redisclose my health information to a third party. The third party may not be required to abide by this authorization or applicable federal and state law governing the use and disclosure of my health information.

I understand that Saint Vincent Hospital may, directly or indirectly, receive remuneration from a third party in connection with the use or disclosure of my health information.

I understand that I may refuse to sign or may revoke in writing (at any time) this authorization for any reason, that such refusal or revocation will not affect the commencement, continuation or quality of my treatment at Saint Vincent Hospital, except, however, if my treatment at Saint Vincent Hospital is for the sole purpose of creating health information for disclosure to the recipient identified in this authorization, in which case Saint Vincent Hospital may refuse to treat me if I do not sign this authorization. If my treatment is related to my participation in a research study, I understand that Saint Vincent Hospital may refuse to treat me if I do not sign this authorization and I would be permitted to designate an expiration date/event of none.

I understand that this authorization will remain in effect until the term of this authorization expires or I provide a written notice of revocation to Saint Vincent Hospital's Privacy Office, c/o Medical Record Department, 123 Summer Street, Worcester, MA 01608. The revocation will be effective immediately upon Saint Vincent Hospital's receipt of my written notice, except that the revocation will not have any effect on any action taken by Saint Vincent Hospital in reliance on this authorization before it received my written notice of revocation.

I have read and understand the terms of this authorization and I have had an opportunity to ask questions about the use and disclosure of my health information. By my signature below, I hereby, knowingly and voluntarily, authorize Saint Vincent Hospital to use or disclose my health information in the manner above.

Signature of Patient or Patient's Legal Representative: _____
Date: _____

What is your relationship to patient? _____

What gives you authority to receive the patient's information?
☐ Written patient authorization *(please attach)*
☐ You are the patient's parent or guardian *(please attach evidence)*
☐ You are the patient's health care decision maker *(please attach evidence such as a medical power of attorney)*
☐ The patient is deceased, and you are the personal representative of the patient's estate *(please attach evidence)*
☐ Other *(please explain)*: _____

Method of Delivery:
☐ I will pick up the records ☐ Please mail them to me ☐ Other: _____

Signature of Employee Validating Identity: _____
Date: _____