St. Joseph Medical Center
Patient Request /Authorization to Use and/or Disclose Protected Health Information

Medical Record # ________________________

I hereby authorize **St. Joseph Medical Center** to use and/or disclose the Protected Health Information specified below from my medical records:

1) PATIENT NAME: (Please Print) ____ Date of Birth: _________________________

Address:____
Street City State Zip

Contact Telephone Number(s): ____

Email: (if applicable)____

2) INFORMATION TO BE DISCLOSED TO:

____
Person or Facility Name (Please print)

____
Address (Please print) City State Zip

____
Email: (if applicable)

Fax #______________________

Phone #____________________

3) Preferred Delivery Method -

- ☐ **Email**
- ☐ **Postal Mail to address in # 2 above**
- ☐ **In Person Pick-Up**

4) Treatment Dates From: ________________________ **To:** ______________________________

5) SPECIFIC RECORDS/REPORTS(S) TO BE RELEASED:

- ☐ Admission History and Physical
- ☐ Discharge Summary
- ☐ Consultation
- ☐ Emergency Room
- ☐ EKG Reports
- ☐ Laboratory Results
- ☐ Imaging Reports (Specify CT, X-Ray, MRI)
- ☐ Pathology Reports
- ☐ Operative Notes
- ☐ Rehab Services (PT, OT, Speech)
- ☐ Other (be specific)

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6) RESTRICTED RELEASE: We will **not** disclose the following documentation **unless** you check the box and provide an additional signature:

Release	Signature	Release	Signature
☐ Mental/Behavioral Health Provider Documentation*		☐ Genetic Testing/Test Results*	
☐ HIV/AIDS Screening Test Results		☐ Alcohol*** and/or ☐ Substance Abuse Treatment***	
☐ Confidential Communications with a Social Worker		☐ Child/Elder Abuse and Neglect	
☐ Rape/Sexual Assault Victim's Counseling		☐ Domestic Violence Victim's Counseling	
☐ Sexually Transmitted Disease			

* This authorization is not valid for use or disclosure of psychotherapy notes

** The term "genetic tests" means only those tests which determine your future chances of developing a disease, not tests done to diagnose a current condition or problem.

***Only applicable to records that are created by an "individual or entity who holds itself out as providing alcohol or drug abuse diagnosis, treatment or referral for treatment." (42 CFR Part 2) Not required for records created or maintained by a general medical facility.

IMPORTANT: THIS AUTHORIZATION IS NOT VALID UNLESS ALL APPLICABLE ENTRIES ARE COMPLETED AND FORM IS SIGNED ON PAGE 2

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7) EXCLUSION REQUEST:
I request that the following admission(s) / visit(s) be specifically excluded from this request ______________________ (specify dates of service)

8) PURPOSE OF THE DISCLOSURE:
☐ Medical Care ☐ Legal ☐ Insurance ☐ Personal ☐ Other____________________

*fees may apply

9) TERM: This Authorization will remain in effect for one year or:

- ☐ Until **St. Joseph Medical Center** fulfills this request.
- ☐ From the date of this Authorization until the ___________________day of__________________20_______
- ☐ Until the following event occurs:____
- ☐ Other: ____

10) REVOCATION: I understand that I may revoke this Authorization at any time by requesting it of **St. Joseph Medical Center** in writing at the address listed below. The revocation will be effective immediately upon **St. Joseph Medical Center** receipt of my written notice. I understand that the revocation will not have any effect on any action taken by **St. Joseph Medical Center** reliance on this Authorization before it received my written notice of revocation.

Attention Health Information Management
St. Joseph Medical Center
1401 Saint Joseph Parkway,
Houston, TX 77002

11) EFFECT ON TREATMENT/PAYMENT/ENROLLMENT/ELIGIBILITY: I understand that I may refuse to sign this Authorization for any reason and that such refusal will not affect the commencement, continuation or quality of my treatment, payment, health plan enrollment or eligibility for benefits at **St. Joseph Medical Center**.

12) POTENTIAL FOR REDISCLOSURE: I understand that the person receiving my Protected Health Information may not be required to comply with federal and state privacy laws, and my Protected Health Information may no longer be protected by the applicable state and federal law once it is disclosed by **St. Joseph Medical Center**.

13) ACCESS: I understand that in certain circumstances **St. Joseph Medical Center** has the right to deny me access to all or portions of my Protected Health Information **St. Joseph Medical Center** will notify me in writing of any such denials.

I have read and understand the terms of this Authorization and I have had an opportunity to ask questions about the use and/or disclosure of my health information. By my signature below, I hereby, knowingly and voluntarily, authorize **St. Joseph Medical Center** to use and/or disclose my health information in the manner described above.

14) ____ ______________________
Signature of Patient Date

For Office Use:
☐ I.D Verification_________________

____
Printed Name of Patient Witness

Authorized patient representative signature. If the patient is a minor or is otherwise unable to sign this Authorization:

15) ____ ______________________
Signature of Personal Representative Date

______________________________ ______________________________
Printed name of Patient Representative Relationship to patient or authority to act for patient

Questions about the release should be directed to the hospital HIM Director.

For Office Use:
- ☐ Copy of this authorization provided to the patient
- ☐ Copy of this authorization provided to the personal representative

IMPORTANT: THIS AUTHORIZATION IS NOT VALID UNLESS ALL APPLICABLE ENTRIES ARE COMPLETED AND FORM IS SIGNED ON PAGE 2

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Signature of Personnel Completing Request Print Name Date Time