

Health Information Management
Department
St. John's Medical Center
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Authorization to Release Medical Information

PATIENT INFORMATION (all must be completed):

Name: _____ DOB: _____ Phone #: _____

Mailing Address: _____

*** Email: _____

1. INFORMATION RELEASED FROM:

HOSPITAL
 PHYSICIAN OFFICE DR: _____

2. INFORMATION DISCLOSED TO:

Individual/Facility (name and address require below) or SELF Phone # _____

Mailing Address _____ Fax # _____

REQUIRED: Dates of Service (last 6 months if not specified) From: _____ To: _____ or _____ OPEN

3. INFORMATION TO BE RELEASED:

<input type="checkbox"/> Emergency Room Record	<input type="checkbox"/> Lab/Blood/Pathology Reports	<input type="checkbox"/> Radiology Images
<input type="checkbox"/> Inpatient Record	<input type="checkbox"/> Cardiopulmonary Records	<input type="checkbox"/> Billing Records
<input type="checkbox"/> Outpatient Record	<input type="checkbox"/> Radiology Reports	<input type="checkbox"/> Physician Office Notes
<input type="checkbox"/> Other: _____		<input type="checkbox"/> All Records

4. PURPOSE OF DISCLOSURE:

Personal Record Medical Insurance Legal Other

5. DELIVERY METHOD (please initial)

Pick Up by Self or Designee _____ (ID required) Mail Fax
 Email: _____

(Note the security of these transmissions cannot be controlled by SJMC)

In the event the facility is unable to accommodate an electronic delivery as requested, an alternative delivery method will be provided (e.g., papery copy). There is a risk that a third party could see your PHI without your consent when receiving by fax or email. Your signature below releases SJMC from liability for unauthorized access to the PHI contained in this format or any risks (e.g, virus) introduced to your computer/device when receiving PHI in electronic format or by fax. Please Note: Your records may contain sensitive data including sensitive test results like HIV and STD. The information used or disclosed pursuant to this authorization may be subject to re-disclosure and no longer be protected under federal law. You have the right to revoke this authorization in writing to the address above. The revocation will not affect any actions taken in reliance on this authorization before the receipt of the written revocation.

SENSITIVE DATA: I understand that my medical records may contain information concerning my mental health and/or psychiatric treatment, and I authorize their release unless denied by my treating physician. I Do Not Authorize Release

This Authorization will expire 1 year from now unless one of these is initialed: One time disclosure No expiration

Signature _____ Date: _____