ST. ALOISIUS MEDICAL CENTER

Sisters of Mary of the Presentation Health System

AUTHORIZATION FOR RELEASE OF INFORMATION

Name of Patient_____Birthdate_____Medical Record Number_____

I hereby authorize_____
(Name and Address of Individual or Organization)

To release to_____
(Name and Address of Individual or Organization to Receive information)

The following information from my medical record for the time period_____

_____Clinical Resume/Discharge Summary	_____Pathology	Internal Use by St Aloisius Staff Completed by:_____
_____History and Physical Report	_____Laboratory Report	
_____Consultation Report	_____Radiology Report	____Other (Please specify)
_____ Operative Report	_____EKG	_____
_____Emergency Room	_____Billing Records	_____

ALL RECORDS PRETAINING TO PSYCHIATRIC/MENTAL HEALTH, ALCOHOL AND/OR DRUD DEPENDENCY, AND/OR HIV/HIV RELATED ILLNESS WILL NOT BE RELEASED UNLESS SPECIFICALLY AUTHORIZED BELOW IN WRITING.

I specifically authorize the release of the following records:

□ Psychiatric /Psychological_____ □ HIV_____ □ Drug and/or Alcohol Dependency_____
(Initials) (Initials) (Initials)

The information is necessary for the following purpose:

_____Diagnosis and Treatment	_____Legal	____Personal:_____
_____Insurance	_____Military	_____Other:_____

This authorization shall remain in effect until the following date, event or condition: _____
If no date, event, or condition is specified, this authorization will expire in one (1) year.

Of Note: Any patient s 14 years or older must authorize the release of their own sensitive information such as psychiatric, mental health, chemical dependency, contraception or STD's.

1. This authorization remains in effect until the above date, event, or condition, unless specifically revoked by written notice to the individual or organization. I understand that this authorization may be revoked at any time. Any information released prior to my written revocation of the A photocopy of this authorization is as effective as the original authorization shall not be breach of confidentiality.
2. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this authorization in order to assure care.
3. I understand that I may inspect or request copies of any information disclosed under this authorization and that I am entitled to a copy of this authorizatior form once I have signed it.
4. I understand that if the individual or organization that receives the information is not a health care provider or health plan covered by federal privacy regulations the information described above may be re disclosed and no longer protected by these federal regulations.
5. A photocopy of this authorization is as effective as the original.

_____ _____ _____
(Signature of Patient or Legal Representative) (Relationship) (Date)

_____
(If patient unable to sign, state reason)