CARONDELET HEALTH NETWORK

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

1) I authorize Carondelet Health Network OR _____ to disclose protected health information from the health records of:

Patient Name: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Telephone: _____ Patient CHN MR#: _____

2) This information is to be disclosed to: *(Name and address of recipient)* *Select one:* *PICK UP* ☐ *MAIL to address below* ☐

Name: _____

Address: _____ City: _____ State: _____ Zip: _____

3) Information to be disclosed: Covering period(s) of health care from (Date) _____ to (Date) _____ or all dates starting with (Date) _____

☐ Complete written health record(s) (OR) Select information as checked below:

☐ Discharge Summary	☐ History and Physical Examination	☐ Progress Notes	☐ X-Ray films/images
☐ Discharge Instructions	☐ Consultation Reports	☐ Laboratory Tests	☐ Itemized Bill
☐ Paper	☐ Procedure Reports	☐ X-ray Reports	
☐ Electronic Copy	☐ Photographs videotapes, digital/other images	☐ Electronic Copy (Based on Availability)	

☐ Other (please specify): _____

4) Purpose or Description of how information will be used:

5) I understand that this may include information relating to the following and *I agree to* its release unless I indicate NO. *Initial required*

_____YES _____ NO AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) infection

_____YES _____ NO Behavioral Health care

_____YES _____ NO Treatment for alcohol and/or drug abuse

_____YES _____ NO Genetic Counseling, testing

6) I understand this authorization may be revoked in writing at any time, except to the extent that action has been taken based upon the authorization. *(Submit to Health Information Management at St. Mary's, St. Joseph's, Holy Cross or Carondelet Heart & Vascular Institute as appropriate)*

7) Unless otherwise noted, this authorization will expire in 12 months from the date of signature.

8) CHN, its associates, directors, and medical staff members are released from any legal liability for disclosure of my protected health information to the extent authorized by this form.

9) I understand that CHN will not condition treatment, payment, enrollment or eligibility on obtaining this authorization, except where federal law allows such condition.

10) I understand that if the organization authorized to receive the health information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

11) I understand there will be a fee for copying these records.

Signature of Patient or Legal Representative Date Time

Signature of Witness Date Time

Printed Name of Patient's Representative: _____

Relationship to or authority to act for the patient: _____

Note: If the patient is unable to consent by reason of age or some other factor(s), state reason:

Identity of Requestor Verified via: ☐ Photo ID ☐ Matching Signature ☐ Other Specify_____

Verified by: _____ Date: _____

All Highlighted questions MUST be answered by patient/representative

☐ When checked, access is denied and letter of explanation given