CHI St. Joseph Health

Authorization to Inspect and Release Protected Health Information

Patient Name:_____ **Birthdate**:_____

Address:_____ **Phone:** (_____)_____

_____

_____

1. I hereby authorize CHI St. Joseph Health to:

☐ Disclose/release the specified health information:

TO: _____

_____

_____

_____

Phone: (_____)_____

Fax No: (_____)_____

☐ Receive the specified health information:

FROM:_____

_____

_____

_____

Phone: (_____)_____

Fax No: (_____)_____

2. The following health information to be disclosed is maintained in the designated record set: (specify the exact information to be disclosed, including dates of service):

☐ Complete medical record Date(s) of Service_____

[OR the records marked below]

- ☐ Emergency Department Record
- ☐ Discharge Summary
- ☐ History & Physical Examination
- ☐ Consultation Reports
- ☐ Progress Notes
- ☐ Report of Procedure
- ☐ Pathology Report
- ☐ (specify) _____

_____

- ☐ Heart Diagram
- ☐ Laboratory Tests
- ☐ Radiology Reports
- ☐ Physicians' Orders
- ☐ Nursing Notes
- ☐ OTHER

☐ Diagnostic films/Digital Images (specify) _____

Please contact the Radiology Department regarding Imaging questions or concerns
Phone (979) 776-2532 or Fax (979) 776-2550

☐ Billing Records (specify) _____

3. For the purpose of: _____

(OVER)

4. If you are requesting copies of your own medical record, indicate here if you would prefer to receive via:

☐ Encrypted CD/DVD

5. I understand that this information may include information relating to specific laboratory tests of HIV infection (Human Immunodeficiency Virus, the causative agent of AIDS) or the diagnosis of Acquired Immune Deficiency Syndrome (AIDS) or AIDS related conditions; treatment for drug or alcohol abuse; mental or behavioral health or psychiatric care, excluding psychotherapy notes.

6. I understand that CHI St. Joseph Health may charge a fee for the costs associated with processing this request.

7. CHI St. Joseph Health may deny this request to inspect and copy health information in certain limited circumstances, which are described in separate policies. If you are denied access, you may request that the denial be reviewed. Another licensed health care professional chosen by CHI St. Joseph Health will review your request and the denial. The person conducting the review will not be the person who denied the request. CHI St. Joseph Health will comply with the outcome of the review.

8. This authorization is given freely with the understanding that:

a) I may revoke this authorization at any time, except where information has already been released.
b) The revocation must be in writing and a form is available from the medical record department.
c) This authorization will expire 180 days from date of signature.
d) CHI St. Joseph Health may not condition treatment or payment upon obtaining this authorization.
e) A photocopy or fax of this authorization is as valid as the original.
f) Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and is no longer protected.

_____
Signature of Patient

_____
Date

_____
Signature of Patient's Representative

_____
Representative's Printed Name

_____
Relationship to Patient

_____
Date

CHI St. Joseph Health Staff

☐ **Verified identity of person picking up records.**

Date verified: _____ Name and Department: _____