AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name: _____ SS #: _____ DOB: _____

Street: _____ City: _____

State: _____ Zip: _____ Phone: _____

Reason for Disclosure: _____

Name of Recipient: _____

Street: _____ City: _____

State: _____ Zip: _____ Phone: _____ Fax: _____

Dates of Treatments being disclosed: From: _____ To: _____

I hereby authorize the use or disclosure of my health information as described below. I understand that this authorization is voluntary and I may refuse to sign it. I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by federal privacy regulations.

☐ Complete Health Record	☐ Radiology Reports	☐ Discharge Summary	☐ Consultatiion Reports
☐ History and Physical Exam	☐ Abstract/Pertinent Information	☐ Progress Notes	☐ Laboratory Tests
☐ Emergency Department Record	☐ HIV/AIDS Information	☐ Drug and Alcohol Treatment Information	

☐ Other: _____

Expiration: If the health information to be disclosed contains HIV/AIDS or drug and alcohol abuse treatment records, this authorization expires in 60 days. Otherwise, you may select either of the following expiration events:

☐ 1 year from the date in which, I, or my legal representative, signs this authorization;

☐ upon the happening of the following event: _____

(Example: "Upon release of the above records.")

Right to Revoke: I understand that I may revoke this authorization at any time by providing written notice to the Director of Medical Records at the address of the facility in which I received my medical care. I understand that my revocation won't have any affect on any action taken by the organization before they received the revocation and is not effective if the authorization was obtained as a condition of obtaining insurance coverage and the insurer has the legal right to contest a claim under my insurance policy.

I understand that the organization will not condition my treatment, payment, enrollment in a health plan, or eligibility for benefits on my signing this authorization.

I understand that I have the right to inspect or copy the health information to be used or disclosed pursuant to this authorization.

TO BE COMPLETED BY THE ORGANIZATION IF THIS AUTHORIZATION IS FOR MARKETING: The organization will receive financial or in-kind compensation in exchange for using or disclosing the health information described above:

☐ Yes ☐ No

Signature: _____ Date: _____

If signed by the patient's legal representative:

Printed name of representative: _____

Relationship to the patient: _____

PROVIDE COPY TO THE PATIENT AND MAINTAIN A COPY IN THE PATIENT'S RECORD

MR.RELEASE

ST. VINCENT CHARITY
MEDICAL CENTER
2351 EAST 22ND STREET
CLEVELAND, OH 44115
stvincentcharity.com
A Ministry of the Sisters of Charity Health System

Please fax request
to Release of Information:
Fax # 216-363-3303
Phone # 216-363-3346