St AGNES HealthCare

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Date Received: _____

Patient Name: _____ **Date of Birth:** _____ **MR#** _____

Address: _____ **Day Phone:** _____

_____ **Fax:** _____

- ☐ **I authorize SAHC to leave follow-up information/instructions on my telephone answering system.**
- ☐ **I authorize SAHC to send the requested PHI to the following email account:** _____
  I understand that the requested documents/images will be sent to me using a secure transmission. Viewing the documents/images may result in the documents/images being stored on the computer that I am using. Therefore viewing these documents/images on public computers is not recommended as the privacy of my protected health information may be compromised. St. Agnes HealthCare may not be held responsible for further disclosure of the documents/images.

I AUTHORIZE SAHC OR OTHER HEALTHCARE PROVIDER _____ **TO RELEASE THE FOLLOWING PHI TO:**

Name: _____ **Telephone:** _____

Address: _____ **FAX:** _____

_____

This information is to be used for the following purpose: ☐ Treatment ☐ Attorney ☐ Insurance
☐ Workers Compensation ☐ Disability ☐ Self ☐ Other _____

Information to be released from the following St. Agnes Healthcare Facilities:

☐ Inpatient/SDS/ ER ☐ Home Care/Hospice ☐ Rehab ☐ Women's Center ☐ Community Care Clinic

☐ Seton Medical Group ☐ ContinuCare ☐ Oncology ☐ Outpatient Clinics/Other _____

Dates of Service: _____

☐ H&P/ Physical Exam	☐ Nursing Notes	☐ Laboratory Data
☐ Discharge Summary	☐ Social Services	☐ Imaging Reports
☐ Consultations	☐ Rehab (PT/OT/ST)	☐ Other Diagnostic Reports
☐ Operative Notes/procedures	☐ Mental Health Assessments	☐ Dietary
☐ Immunization Record	☐ Respiratory Reports	☐ Pharmacy
☐ Summary of Record Set	☐ Other _____	☐ Entire Record

_____ Initials There may be a processing fee for copying and handling your request. Initial if advance notice of cost is desired; otherwise you will be billed for this service. Day Phone: _____ After you receive notice of any applicable charges, you may cancel this request without charge.

I understand that I may revoke my authorization to disclose/use my protected health information by completing a Revocation of Authorization Form. This does not affect disclosure of information already made. I understand SAHC does not condition treatment on the completion of the authorization. This authorization will expire one year from the date or otherwise as stated: _____

Signed: _____ Date : _____
(Signature of patient or personal representative)

_____
Relationship to Patient/authority to act on behalf of the patient.

NOTICE TO RECIPIENT OF INFORMATION: This information has been disclosed in accordance with Subtitle 3 of 4 of the Annotated Code of Maryland. Any individual or agency receiving this information is prohibited from making further disclosure of this information as provided by 4-303(b)(5) (ii). If this information concerns a person admitted for treatment of alcohol or drug abuse, the confidentiality of this information is protected by federal law (Federal Regulation 42 CFR Part 2) and prohibits further disclosure of this information except with specific written consent of the person to whom it pertains. A general authorization for the release of medical or other information, if held by another party, is not sufficient for this purpose.