Completion of this document authorizes the disclosure and/or use of health information about you.

Failure to provide *all* information requested may invalidate this authorization. Fees to reproduce records may apply.

**USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION:**

Name of Patient:_____Date of Birth:_____

Other Names Used: _____Telephone Number: _____

Medical Record or Account#:_____

(Hospital use only)

I AUTHORIZE :_____

(Facility or other provider)

TO DISCLOSE TO: _____

(Persons/organizations authorized to receive the information)

at the following address:_____

EMAIL: (street, city, state and zip code) PHONE/FAX:

the following information (check box and initial applicable lines below):

____Mental health records (excludes "psychotherapy notes")

____Substance abuse treatment records

____HIV related information and other communicable diseases.

____Genetic testing information

❑ **THE FOLLOWING RECORDS**, specific types of health information, or records for the date(s) of treatment as specified [check applicable box(es)]:

| | | |
|---|---|---|
| ❑ Billing Records | ❑ Emergency Room | ❑ Procedure Reports |
| ❑ Consultation Reports | ❑ History and Physical | ❑ Progress Notes |
| ❑ Discharge Summary | ❑ Laboratory Tests | ❑ X-ray Reports |

❑ Date(s):_____

❑ Other(s):_____

❑ **ALL RECORDS (Fee May Apply)**

regarding my treatment, hospitalization, and outpatient care. A separate authorization is required for the use or disclosure of psychotherapy notes or research health information.

Dignity Health.
St. Joseph's Hospital and Medical Center

**AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION**

ROI

Patient Label

**PURPOSE:** The purpose and limitations (if any) of the requested use or disclosure is:

- ❑ At the request of the patient or personal representative; ***OR***
- ❑ Other:_____

**EXPIRATION:** This authorization will automatically expire one (1) year from the date of execution unless a different event or end date is specified: _____

(insert date or event)

**MY RIGHTS:**

- I may refuse to sign this authorization. My refusal will not affect my ability to obtain treatment or payment or eligibility for benefits.
- I may revoke this authorization at any time, but I must do so in writing and submit it to the following address:

*Facility Privacy Officer*
*St. Joseph's Hospital & Medical Center*
*350 West Thomas Road, Phoenix, AZ 85013*

My revocation will take effect upon receipt, except to the extent that others have acted in reliance upon this authorization.

Information disclosed pursuant to this authorization could be re-disclosed by the recipient. Such re-disclosure is in some cases not protected by Arizona law and may no longer be protected by federal confidentiality law (HIPAA). If this authorization is for the disclosure of substance abuse information, the recipient may be prohibited from disclosing the information under 42 C.F.R. part 2.

**SIGNATURE:** _____Date:_____

(Patient or personal representative)

_____ _____

Print name of personal representative Relationship to patient

Patient/Representative Identification Verified. *Initials:*_____ *Dept:*_____

**Note: If the substance abuse treatment information is protected by federal confidentiality rules (42 C.F.R. part 2) the following prohibition of re-disclosure statements must be provided to the recipient of the information:**

**The federal rules prohibit the recipient from making any further disclosure of the information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains, or as otherwise permitted by 42 C.F.R. part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.**

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