St. Vincent Hospital

Here for you, your family, your community.

Patient Label

Patient Authorization to Disclose Protected Health Information (PHI) *St. Vincent Hospital has 10 business days to complete this request.

Patient's Full Name:	Date of Birth	Last 4 of Social Security #:
Street Address:	City, State, Zip Code	Telephone #:
E-mail Address:		

I hereby authorize the facility listed below to disclose/release the Protected Health Information specified in this request to the organization, agency or patient named.

Release By:	**Release To:**
Facility Name	**Facility Name**
Address	**Address**
City, State, Zip Code	**City, State, Zip Code**
HIM Phone #:	**HIM Phone #:**
Fax #:	**Fax #:**

Treatment Date(s): _____ - _____

Purpose:

- ☐ Further Medical Care
- ☐ Worker's Comp
- ☐ Personal Use
- ☐ Insurance
- ☐ Legal
- ☐ Marketing/ Fundraising
- ☐ Other: _____

Type of Disclosure Authorized & Delivery Instructions:

- ☐ Provide Copies of records to Organization/Agency/ Individual listed above.
- ☐ Mail records directly to address above
- ☐ Call to pick-up records: _____
- ☐ Fax records to: _____

Pertinent Protected Health Information (PHI) Authorized to be included:

- ☐ Discharge Summary
- ☐ Radiology
- ☐ Special Studies
- ☐ H & P (s)
- ☐ Consult
- ☐ Out PT Record(s)
- ☐ RX Record(s)
- ☐ Op Report(s)
- ☐ Progress Note(s)
- ☐ Psych Health Record(s)
- ☐ Lab Result(s)
- ☐ Physician Order(s)
- ☐ Medcial Record
- ☐ Other (Specify): _____

***Psychotherapy Notes are distinct and may not be included with the disclosure of any other protected health information. A Patient Authorization to Disclose Psychotherapy Notes must be completed.**

Authorization: I certify that this request is made voluntarily and that the information given above is accurate to the best of my knowledge. I understand that I may revoke this authorization at any time in writing by submitting my request in writing to the designated Health Information Management I Medical Records department. If I have authorized the disclosure of my health information to someone who is not legally required to keep it private, it may be re-disclosed and may no longer be protected. A copy or fax of this authorization will be as valid as the original.

I understand that authorizing disclosure of health information is voluntary. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment, or my eligibility to obtain benefits. I understand that I may inspect or obtain a copy of the information to be disclosed. I understand a fee may be charged for copies of my medical record. I understand the facility will provide me a copy of the signed authorization form. If I have questions about disclosure of my health information, I can contact the designated Corporate Responsibility and Privacy Officer.

Expiration: Without my express revocation, this authorization will automatically expire upon satisfaction of the need for disclosure, but in any event will expire 90 days from the date hereof, unless a different date is specified here:

Acknowledgement: I understand that the information to be disclosed may include any or all information involving communicable or venereal disease, psychological or psychiatric conditions, drug or alcohol abuse and/or alcoholism. It may also include, but is not limited to, diseases such as hepatitis, syphilis, gonorrhea and human immunodeficiency viruses (HIV), also known as acquired immune deficiency syndrome (AIDS).

For Marketing/Fundraising Purposes Only, if applicable: I understand that St. Vincent General Hospital District (SVGHD): ☐ will ☐ will not receive remuneration, either direct or indirect, as a result of the marketing that I hereby authorize.

Signature of Patient / Parent - Legal Representative: _____ Date/Time: _____/_____

If Legal Representative, Print Name: _____ Relationship to Patient:_____

Minor's signature is required for release of any records for treatment which the minor may authorize under Colorado Law.

SVGHD Use Only Request Received By: _____ Date Received: _____

Medical Record #: _____ Identity Verification (DL# / Other ID#): _____

Date Completed: _____/_____/_____ Completed By: _____