Authorization To Release Protected Health Information

*Used by

I (the undersigned) hereby authorize the St. Vincent Facility indicated below to disclose/obtain the following identified information. Please only select one location per form.

☐ St. Vincent Evansville ☐ St. Vincent Medical Group ☐ Physician's Office:____________________
Telephone: ______________________________

PATIENT VISIT INFORMATION

Name of Patient	Phone Number	Date of Birth
Other Names used during treatment (if applicable)		
Address	City, State, Zip Code	
Purpose of Disclosure	EMAIL	

RELEASE INFORMATION TO IF NOT PATIENT:

Name	
Address	Phone Number
City, State, Zip Code	

INFORMATION TO BE RELEASED (limit request to the minimum necessary)
Dates of Treatment______________________

	PROCEDURE REPORT		REHAB SERVICES		CARDIAC TESTING
	DICTATION		RADIOLOGY REPORTS		ER REPORTS
	ABSTRACT: DICTATION, LABS, RADIOLOGY AND ER REPORTS		LAB AND PATHOLOGY REPORTS		DISCHARGE SUMMARY/ SHORT STAY NOTE
	OTHER: Please Specify				

- o I understand that the Protected Health Information in my medical record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.
- o I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the address below. I understand that a revocation is not effective to the extent that St. Vincent has relied on the use of disclosure of the protected health information. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.
- o I understand that this authorization will expire in sixty (60) days unless otherwise specified here. ________________________
- o I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.
- o St. Vincent will not condition my treatment, payment, enrollment (if applicable) in a health plan or eligibility for benefits on whether I provide authorization for the requested use or disclosure.
- o I understand that I am responsible for paying the applicable fees , if any I have the right to an estimate of the fees before receiving a copy of the records
- o By signing this authorization, I acknowledge that I have read and understand this authorization. Further, I authorize the use or disclosure of my Protected Health Information in accordance with the terms of this authorization.

Signature of Patient, Guardian, Parent, or Health Representative	**Date Signed**
Relationship to patient (if other than self or your minor child we will require proof of authority to act on behalf of patient)	

FOR HIM USE ONLY		
☐ ID or Signature Checked	☐ Unable to verify signature REASON:	
HIM signature	DATE	
#PGS	COPIES WERE: ☐ Mailed to requester ☐ Picked Up ☐ Faxed	Date Sent/ Picked up/Faxed

'Authorization must be signed by the parent or legal guardian of any patient under 18; the legal guardian of any patient under guardianship; the personal representative of a deceased patient, or if no personal representative, the spouse, any adult child of a deceased patient (Chapter 8 of 1.C 16-4, Acts of 1982).