



St. Vincent Warrick
1116 Millis Ave., Boonville, IN 47601

Patient Sticker

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION - PAGE 1 OF 1

I (the undersigned) hereby authorize the St. Vincent Facility indicated below to disclose/obtain the following identified information.

St. Vincent Warrick Hospital

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 OF 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:

| | | | | | |
|--------------------------|---|--------------------------|---------------------------|--------------------------|-------------------------------------|
| <input type="checkbox"/> | PROCEDURE REPORT | <input type="checkbox"/> | REHAB SERVICES | <input type="checkbox"/> | CARDIAC TESTING |
| <input type="checkbox"/> | DICTATION | <input type="checkbox"/> | RADIOLOGY REPORTS | <input type="checkbox"/> | ER REPORTS |
| <input type="checkbox"/> | ABSTRACT: DICTATION, LABS, RADIOLOGY AND ER REPORTS | <input type="checkbox"/> | LAB AND PATHOLOGY REPORTS | <input type="checkbox"/> | DISCHARGE SUMMARY / SHORT STAY NOTE |
| <input type="checkbox"/> | OTHER: Please Specify | | | | |

- 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.
- 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.
- I understand that this authorization will expire in sixty (60) days unless otherwise specified here.
- 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.
- 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.
- 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.
- 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: <input type="checkbox"/> mailed to requester <input type="checkbox"/> Picked Up <input type="checkbox"/> Faxed | Date Sent / Picked up / Faxed |