SPOC8090

# PATIENT REQUEST FOR RELEASE OF INFORMATION

St. Bernards HEALTHCARE

Patient Name _____ SSN _____ DOB _____ Phone _____

Healthcare Provider: _____

**FILL OUT THIS SIDE IF DISCLOSURE WILL BE MADE TO PATIENT OR PERSONAL REPRESENTATIVE:**

I hereby request that the Healthcare Provider disclose the information outlined below to me.

**METHOD OF DELIVERY**

- ☐ Pick up
- ☐ Email records to the following email address: _____
- ☐ Mail records to me at the following address: _____
- ☐ Other: _____

**FORMAT OF RECORDS**

- ☐ Paper
- ☐ Electronic

**FILL OUT THIS SIDE IF DISCLOSURE WILL BE MADE TO A THIRD PARTY:**

I hereby request that Healthcare Provider disclose the information outlined below to:

Name: _____
Email: _____
Address: _____

**METHOD OF DELIVERY**

- ☐ Pick up
- ☐ Email to above email address
- ☐ Mail to above address
- ☐ Oral
- ☐ Other: _____

**FORMAT OF RECORDS**

- ☐ Electronic

**INFORMATION TO BE DISCLOSED**

Date(s) of service to be disclosed:

- ☐ ____/____/____ to ____/____/____
- ☐ ALL DATES OF SERVICE

Type(s) of information to be disclosed:

| | | |
|---|---|---|
| ☐ **ENTIRE MEDICAL RECORD** | ☐ Progress Notes | ☐ Itemized Statement |
| ☐ History / Physical | ☐ Nurses Notes | ☐ Physician's Orders |
| ☐ Discharge Summary | ☐ Medication Records | ☐ Other (please specify): |
| ☐ Consultation Report | ☐ Laboratory Results | _____ |
| ☐ Operative Report | ☐ Radiology Results | _____ |

**PLEASE CHECK THE BOXES BELOW IF YOU WANT THIS RELEASE TO INCLUDE THE INDICATED INFORMATION. IF A BOX IS NOT CHECKED, THE INFORMATION WILL BE EXCLUDED.**

☐ Mental Health Records ☐ Substance Use Disorder Records ☐ HIV / AIDS Test Results

This disclosure can be used for the following purpose(s): ☐ Legal ☐ Insurance ☐ Medical Certification ☐ Other _____

I understand that the information in my health record may include information relating to sexually transmitted disease(s), 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.

**REVOCATION AND EXPIRATION**

This authorization may be revoked at any time except to the extent that action has already been taken in reliance thereon. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Privacy Officer at 225 E. Washington Street, Jonesboro, AR 72401 (870.207.4422). I understand that revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____
If I fail to specify an expiration date, event, or condition, this authorization will expire in six (6) months.

**FAILURE TO SIGN AUTHORIZATION**

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in 45 CFR § 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and that the information may then no longer be protected by federal confidentiality rules. If I have questions regarding disclosure of my health information, I can contact the Privacy Officer at the above-referenced address and telephone number.

_____ _____
Signature of Patient or Personal Representative Date / Time

_____ _____
If signed by Personal Representative, Relationship to Patient Signature of Witness