St Paul Medical Center
Patient Request /Authorization to Use and/or Disclose Protected Health Information

Medical Record #_____

I hereby authorize **St Paul Medical Center** to use and/or disclose the Protected Health Information specified below from my medical records:

1) PATIENT NAME: (Please Print) _____ Date of Birth: _____

Address:_____
Street City State Zip

Contact Telephone Number(s): _____

Email: (if applicable)_____

2) INFORMATION TO BE DISCLOSED TO:

_____
Person or Facility Name (Please print)

_____
Address (Please print) City State Zip

_____
Email: (if applicable)

Fax #_____

Phone #_____

3) Preferred Delivery Method -

- ☐ **Email**
- ☐ **Postal Mail to address in # 2 above**
- ☐ **In Person Pick-Up**

4) Treatment Dates From: _____ **To:** _____

5) SPECIFIC RECORDS/REPORTS(S) TO BE RELEASED:

☐ Admission History and Physical	☐ Laboratory Results	☐ Rehab Services (PT, OT, Speech)
☐ Discharge Summary	☐ Imaging Reports (Specify CT, X-Ray, MRI)	☐ Other (be specific)
☐ Consultation	☐ Pathology Reports	_____
☐ Emergency Room	☐ Operative Notes	_____
☐ EKG Reports		

6) RESTRICTED RELEASE: We will **not** disclose the following documentation **unless** you check the box and provide an additional signature:

Release	Signature	Release	Signature
☐ Mental/Behavioral Health Provider Documentation*		☐ Genetic Testing/Test Results*	
☐ HIV/AIDS Screening Test Results		☐ Alcohol*** Treatment*** and/or ☐ Substance Abuse	
☐ Confidential Communications with a Social Worker		☐ Child/Elder Abuse and Neglect	
☐ Rape/Sexual Assault Victim's Counseling		☐ Domestic Violence Victim's Counseling	
☐ Sexually Transmitted Disease			

* This authorization is not valid for use or disclosure of psychotherapy notes

** The term "genetic tests" means only those tests which determine your future chances of developing a disease, not tests done to diagnose a current condition or problem.

***Only applicable to records that are created by an "individual or entity who holds itself out as providing alcohol or drug abuse diagnosis, treatment or referral for treatment." (42 CFR Part 2) Not required for records created or maintained by a general medical facility.

IMPORTANT: THIS AUTHORIZATION IS NOT VALID UNLESS ALL APPLICABLE ENTRIES ARE COMPLETED AND FORM IS SIGNED ON PAGE 2

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7) EXCLUSION REQUEST:
I request that the following admission(s) / visit(s) be specifically excluded from this request _____ (specify dates of service)

8) PURPOSE OF THE DISCLOSURE:
☐ Medical Care ☐ Legal ☐ Insurance ☐ Personal ☐ Other_____
*fees may apply

9) TERM: This Authorization will remain in effect for one year or:

☐ Until St Paul Medical Center fulfills this request.
☐ From the date of this Authorization until the _____day of_____20_____
☐ Until the following event occurs:_____
☐ Other:_____

10) REVOCATION: I understand that I may revoke this Authorization at any time by requesting it of St Paul Medical Center in writing at the address listed below. The revocation will be effective immediately upon **St Paul Medical Center of Dallas** receipt of my written notice. I understand that the revocation will not have any effect on any action taken by **St Paul Medical Center of Dallas Texas** reliance on this Authorization before it received my written notice of revocation.

Attention Health Information Management
St Paul Medical Center
12770 Coit Rd.,
Dallas, TX 75251

11) EFFECT ON TREATMENT/PAYMENT/ENROLLMENT/ELIGIBILITY: I understand that I may refuse to sign this Authorization for any reason and that such refusal will not affect the commencement, continuation or quality of my treatment, payment, health plan enrollment or eligibility for benefits at **St Paul Medical Center**.

12) POTENTIAL FOR REDISCLOSURE: I understand that the person receiving my Protected Health Information may not be required to comply with federal and state privacy laws, and my Protected Health Information may no longer be protected by the applicable state and federal law once it is disclosed by **St Paul Medical Center.**

13) ACCESS: I understand that in certain circumstances **St Paul Medical Center** has the right to deny me access to all or portions of my Protected Health Information **St Paul Medical Center** will notify me in writing of any such denials.

I have read and understand the terms of this Authorization and I have had an opportunity to ask questions about the use and/or disclosure of my health information. By my signature below, I hereby, knowingly and voluntarily, authorize **St Paul Medical Center** to use and/or disclose my health information in the manner described above.

14) _____ _____
Signature of Patient Date

_____
Printed Name of Patient Witness

For Office Use:
☐ I.D Verification_____

Authorized patient representative signature. If the patient is a minor or is otherwise unable to sign this Authorization:

15) _____ _____
Signature of Personal Representative Date

_____ _____
Printed name of Patient Representative Relationship to patient or authority to act for patient

Questions about the release should be directed to the hospital HIM Director.

For Office Use:
☐ Copy of this authorization provided to the patient
☐ Copy of this authorization provided to the personal representative

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Signature of Personnel Completing Request | Print Name | Date | Time