

**AUTHORIZATION TO USE/DISCLOSE PROTECTED HEALTH INFORMATION**

I desire to release the medical information for the patient indicated below for the purposes of

establishing and coordinating care and updating records maintained at Saint Moscati. I understand that my establishing or receiving medical care is NOT contingent upon signing this form. I understand the release of this information is intended to assist the Providers at Saint Moscati to care for the patient indicated below.

I understand this authorization may be revoked in writing at any time by providing a written

statement to the address above. No revocation will be retroactive to pertain to records already

released. This consent will expire one year from the date of signing unless otherwise indicated.

I understand the information used or disclosed may be subject to re-disclosure except for highly

confidential information to include “Sensitive Information”. The undersigned hereby releases Saint Moscati from any liability which may arise from the release and/or examination of the information indicated above. I have read this authorization, and I understand it.

I authorize \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_to release a copy of medical information

Hospital/Health Care Provider

For: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Patient Date of Birth Telephone Number

For the purpose of: \_\_\_ Patient Care \_\_\_ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

To:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

By placing my initials in the spaces below, I indicate my approval for the release of the following medical records (for the past 5 years), if such exist, to be sent.

\_\_\_\_\_ Office Visit Notes/Chart Summaries \_\_\_\_\_Lab and Diagnostic Results

\_\_\_\_\_ Current Medication List \_\_\_\_\_ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_ I understand the information in my health record may include “Sensitive Information”

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.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of patient or person authorized by law Date:

Relationship to Patient: \_\_\_\_\_\_\_\_ Parent/Legal Guardian \_\_\_ Personal Representative