55-0702 (08-2013)

55-0702

I, _____, [**Print** Name of Individual]

Date of Birth _____, **Social Security #:** _____

hereby authorize _____ (name of individual or department) to release information to ☐ from ☐ St. Joseph Medical Center to use and/or disclose my individually identifiable health information as described below:

I authorize the following person(s) or organization(s) to receive/send information about my treatment and therapy:

_____

Street Address: _____

City, State and Zip Code: _____

The following individually identifiable health information may be used and/or disclosed:
Check (✓) all that apply:

__ Standard Abstract	__ Reports of Tests & X-rays	__ Inpatient Records
__ Discharge Summary	__ Emergency Room Records	__ Outpatient Records
__ Consultation Reports	__ Immunization (shot) Record	__ Physical Therapy Notes
__ History and Physical Records	__ Outpatient Clinic Notes	__ Billing Information

__ Other: _____

Dates of treatment to be released: _____

I authorize the release of any information contained in the above records concerning treatment of drug or alcohol abuse, drug related conditions, alcoholism, psychiatric/psychological condition, psychiatric/ mental health treatment and/or HIV-related conditions.

Reason or purpose for the use and/or disclosure of the information: _____

_____

Prohibition on Conditioning of Authorization: St. Joseph Medical Center will not condition treatment on your signing this authorization, unless:
- You are receiving research-related treatment; or
- The only reason the facility is providing you with health care is to make a report to a third party, such as your employer (e.g., fitness to return to work) or school (e.g., physical education physical).

(Please continue on reverse side)

If authorization is for marketing, indicate if St. Joseph Medical Center will receive compensation in exchange for the use and/or disclosure of the PHI. __ YES __NO __NA

Re-disclosure: I understand that the information used and/or disclosed according to this authorization may be re-disclosed by the recipient of the information and may no longer be protected by federal law.

Expiration: This authorization will expire in ninety (90) days.

Revocation: I understand that I may revoke this authorization at any time by notifying St. Joseph Medical Center in writing by sending a letter to Health Information Management Department, St. Joseph Medical Center, 7601 Osler Drive, Towson, MD 21204 or completing the Revocation of Authorization form. I understand that if I revoke this authorization, it will not affect any actions that St. Joseph Medical Center took before it received my revocation letter. For example, St. Joseph Medical Center cannot rescind disclosures it has already made, and may use my health information as necessary to bill and collect for services rendered.

This Authorization is binding: The statements made in this authorization are binding, controlling and I understand that they take precedence over statements made in the St. Joseph Medical Center's Notice of Privacy Practices.

_____ _____

Signature of Individual or Personal Representative Date

Printed name of individual's personal representative, if applicable: _____

Rationale for serving as personal representative to the individual (e.g., parent, legal guardian):

To contact the Health Information Management Department Correspondence Copy Service Call: Phone: 410-337-1169

Acknowledgement:

I acknowledge receiving a signed copy of this authorization. _____

Signature

FOR INTERNAL PURPOSES ONLY

Staff Personnel:

Received by: _____ Date: _____

Was a signed copy provided to the individual and acknowledged? __ YES __ NO

Was copy of photo identification provided? __ YES __ NO