CHI Saint Joseph Health

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION ACCESS TO PROTECTED HEALTH INFORMATION

I, _____, [**Print Name of Individual**], Date of Birth: _____

Last 4 digits of SSN: _____, hereby authorize _____ [**Insert Facility Name, See Back**]

to use and/or disclose my individually identifiable health information as described below. I authorize the following person(s) or organization

_____ receive the information in ❑ Paper or ❑ Electronic form.

Street Address: _____ Telephone #: _____

City, State, and Zip Code: _____

The following individually identifiable health information may be used and/or disclosed:

Check all that apply:

❑ Discharge Summary	❑ Facesheet	❑ Emergency Room Records	❑ Reports of Lab Tests
❑ History and Physical Records	❑ Consultation Reports	❑ Reports of X-rays	❑ Operative Reports
❑ Physical Therapy Notes	❑ All		

❑ 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: CHI Saint Joseph Health 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., P.E. physical).

Re-disclosure: I understand that the information used and/or disclosed according to this authorization may no longer be protected by federal privacy law (also known as HIPAA) and the recipient of your health information may potentially redisclose it. However, under the Federal Substance Abuse Confidentiality Requirements, 42 CFR Part 2, the recipient may be prohibited from disclosing identifiable substance abuse information.

Expiration: This authorization will expire 90 days from the date signed.

Revocation: I understand that I may revoke this authorization at any time by notifying CHI Saint Joseph Health in writing by sending a letter to Health Information Management at the specific facility address or completing the Revocation of Authorization form. I understand that if I revoke this authorization, it will not affect any actions that CHI Saint Joseph Health took before it received my revocation letter. For example, CHI Saint Joseph Health 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 CHI Saint Joseph Health's Notice of Privacy Practices.

I understand a fee may be charged for copies of my medical record.
Mail the completed authorization form and a copy of your ID to the appropriate facility address listed on the 2nd page of this autorization.

_____

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):

Witness: _____ Date: _____

FOR INTERNAL PURPOSES ONLY
When CHI Saint Joseph Health is requesting an authorization to use health information for its own use, the following provision must be completed:

Staff Personnel:

Received by: _____ Date: _____

Was a signed copy provided to the individual? ❑ YES ❑ NO
Access approved? ❑ YES ❑ NO

PATIENT IDENTIFICATION

MR-112

CHI Saint Joseph Health Guide to Obtaining Medical Records

To assist you with obtaining your medical records in a timely fashion please direct your request to the appropriate facility listed below.

To obtain medical records from the providers listed below mail the completed authorization form and a copy of your id to the address listed:

Saint Joseph Hospital
Saint Joseph East
Saint Joseph Jessamine
Phone: 1-859-313-1185
Health Information Management
Attn: Release of Information
One Saint Joseph Drive, Lexington, Ky. 40504

Saint Joseph Berea
Phone: 1-859-986-6555
Health Information Management
Attn: Release of Information
305 Estill Street, Berea, Ky. 40403

Saint Joseph Mount Sterling
Phone: 1-859-497-5057
Health Information Management
Attn: Release of Information
225 Falcon Drive, Mt Sterling, Ky. 40353

Saint. Joseph London
Phone: 1-606-330-6678
Health Information Management
Attn: Release of Information
1001 Saint Joseph Lane, London, Ky. 40741

Flaget Memorial
Phone: 1-502·350-5065
Health Information Management
Attn: Release of Information
4305 New Shepherdsville Road, Bardstown, Ky. 40004