St Joseph's
Healthcare System
St. Joseph's Regional Medical Center
St. Joseph's Wayne Hospital
A Division of St. Joseph's Regional Medical Center
St. Vincent's Nursing Home

PATIENT ID HERE

AUTHORIZATION FOR THE RELEASE OF PATIENT INFORMATION

Individual's Name: _____

Home Address: _____

Home Telephone: _____ Date of Birth: _____

SPECIFY INFORMATION TO BE DISCLOSED: (e.g., abstract, lab results, etc.) _____

_____ Specify Date of Service: _____

SPECIFY ANY INFORMATION THAT I DO NOT WISH TO BE DISCLOSED:

_____

☐ SENDER: Name of person, entity or class of person authorized to release the above information to the Facility:

_____

☐ RECIPIENT: Name of person or class of persons to whom the Facility may disclose the above information:

_____

Address of where my health information should be delivered: _____

_____

TERM: This authorization will remain in effect for one year from the date of signature unless I note otherwise.

Alternatively, I wish this authorization to remain in effect only until _____.

PURPOSE: I authorize my health information (including highly confidential information unless I specify otherwise) to be sent to or by the Facility and it may be used and disclosed during the term of this Authorization for the following specific purposes: (Note: "at the request of the patient" is sufficient if the patient is initiating this Authorization):

_____

I understand that once my health information is disclosed, there is no guarantee that the Facility or the recipient will not redisclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.

I also understand that my record may contain information regarding my mental health, HIV/AIDS, genetic information. venereal disease information, tuberculosis information, or information regarding drug and/or alcohol testing or treatment. By signing this authorization, if I request release of my records, I am authorizing release of any of the above information as well as any other information that may be included in my records. If I do not wish any of this information (or any other information) released, I will note that above under "specific information that I do not wish to be disclosed."

I know that I may refuse to sign or may revoke (at any time) this authorization for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of my treatment at the Facility or the entity sending the information (if applicable). Except, however, if my treatment at the Facility is for the sole purpose of creating health information for disclosure to the recipient identified in this authorization, in which case the Facility may refuse to treat me if I do not sign this authorization. In addition, ONLY if my treatment is related to my participation in a research study, I understand that the Facility may refuse to treat me if I do not sign this Authorization, and that this authorization will have no expiration date.

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AUTHORIZATION FOR THE RELEASE OF PATIENT INFORMATION

If I wish to revoke this Authorization before the above termination date (which is one year from when I sign this authorization unless I note otherwise, or if my treatment is related to my participation in a research study), I must provide a written notice to the Privacy Officer. Revocation will not have any effect on any action the Facility has already taken in reliance on this Authorization before it received my written revocation.

I have read this Authorization and have had a chance to ask questions about the use and disclosure of my health information. By signing below, I voluntarily authorize the Facility to use or disclose my health information in the manner described above.

SIGNATURE OF PATIENT OR PATIENT'S PARENT, GUARDIAN OR REPRESENTATIVE _____ DATE / _____ TIME

***(NOTE:* This form MUST be completed before signing.)**

If patient is unable to sign his/her name, a witness must sign here:

_____

If this authorization is signed by a patient's parent, guardian or representative, please complete the following:

_____
PRINTED NAME OF PATIENT'S REPRESENTATIVE

_____
RELATIONSHIP TO THE PATIENT

Describe the representative's authority to act for the patient:

_____

_____

_____

_____

I also give the Facility permission to use my health information for marketing purposes, so that I may be sent information about various products and/or services. I realize that the Facility may be paid for this information.

Signed: _____ *(patient or representative)*

– YOU MAY REFUSE TO SIGN THIS AUTHORIZATION –