

Health Information Systems

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ST. ANTHONY COMMUNITY HOSPITAL

Bon Secours Charity Health System



15 Maple Avenue

Warwick, NY 10990

www.StAnthonyCommunityHosp.org

Authorization For Disclosure of Patient Health Information

Patient Name: _____

Medical Record Number: _____

Date of Birth: _____

1. I authorize St. Anthony Community Hospital to disclose the following information from my health record as maintained by the Hospital:

- _ entire record
- _ emergency room record from _____(date)
- _ most recent discharge summary
- _ most recent history and physical examination report
- _ most recent operative report
- _ lab results from _____(date) to _____(date)
- _ radiology results from _____(date) to _____(date)
- _ consultation reports from (please supply doctors' names):
- _ progress notes
- _ medication lists
- _ other (please describe): _____

2. The information identified above may be used by or disclosed to the following individuals or organization(s):

Name: _____

Address: _____

Name: _____

Address: _____

3. This information for which I am authorizing disclosure will be used for the following purpose:

- _ my personal records
- _ sharing with other health care providers as needed
- _ other (please describe): _____

4. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Health Information Management Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

5. Unless I specify differently, this authorization will expire (insert date or event):_____

If I fail to specify an expiration date or event, this authorization will expire six months from the date on which it was signed.

6. I understand that once the above information is disclosed, it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

By signing this authorization, I acknowledge that I have read and understand this authorization. Further, I authorize the disclosure of my health information maintained by St. Anthony Community Hospital in accordance with the terms of this authorization.

- A Copying and Processing Fee May Be Charged

Signature of patient or legal representative

Date

If signed by legal representative, relationship to patient _____

Date

Signature of witness

Date

I understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment; receive payment; or eligibility for benefits unless allowed by law.

This authorization does not apply to disclosure of information relating to HIV/AIDS virus, Drug/Alcohol Abuse/Treatment or Mental Health Services. A special consent is required by New York State Law for disclosure of this protected health information.

For Hospital Use:

Picture Identification is shown Yes _____ No _____

If no, other form of I.D. shown is: _____(specify)

A COPY OF THIS SIGNED AUTHORIZATION WILL BE GIVEN TO THE INDIVIDUAL