ST. Joseph's/Candler

Authorization for Release of Information

Purposes of HIPAA Disclosure

I hereby authorize SJ/C Physician Network to release OR receive the following information from the health records of:

Patient Name:_____ DOB: _____ SSN:_____

To Be Released To:

First and Last Name	Relationship	Date of Birth	Phone Number

Information to Be Released:

- ☐ Entire Record
- ☐ Emergency Room Notes
- ☐ Lab Results
- ☐ Radiological Results
- ☐ Nursing Notes
- ☐ Physician Orders
- ☐ Demographics
- ☐ Medication Records

For The Purpose Of:

- ☐ Anything on behalf of the patient
- ☐ Creating/Changing/Canceling appointments
- ☐ View or correct demographic information to include signing in on my behalf
- ☐ Receive documents containing my PHI (Protected Health Information) on my behalf with an authorization for release of information signed by me.
- ☐ Picking up prescriptions/forms and or medications on my behalf.
- ☐ Speaking to SJ/C Physician Network staff regarding my PHI including but not limited to billing and insurance information on my behalf.
- ☐ Other: _____

I understand that I can revoke this authorization by providing written notice to the Health Information Department of St. Joseph's/Candler Physician Network or in a manner described in the Notice of Privacy Rights. I also understand that if the information has been released by relying upon this Authorization, that revocation will not be valid.

I PLACE NO LIMITATIONS ON HISTORY OF ILLNESS OR DIAGNOSTIC AND THERAPEUTIC INFORMATION, INCLUDING ANY TREATMENT FOR ALCOHOL, DRUG ABUSE OR DEPENDENCY, PSYCHIATRIC OR PSYCHOLOGICAL ILLNESS, MENTAL ILLNESS OR RETARDATION AND ACQUIRED IMMUNE DEFICIENCY (AIDS) SYNDROME.

The physician's office listed above may not condition treatment, payment, on the signing of this authorization, unless allowed by law.

I understand that I am waiving my rights to privacy by releasing my medical information to the parties listed above and this information may be re-disclosed by the receiving party. I hereby authorize the entity listed above to release the said information described above. I understand that this Release of Information will expire within **ONE YEAR** from the date listed below.

_____ _____

Patient Signature Date

_____ _____

Patient's Guardian or Capacity *Date*

_____

Relationship to Patient

ST. Joseph's/Candler

Authorization for Release of Information

I hereby authorize SJ/C Physician Network to release OR receive the following information from the health records of:

Name: _____ Date of Birth: _____

Social Security Number: _____

☐ OBTAIN FROM	☐ RELEASE TO
_____ Name of Entity or Physician	_____ Name of Entity or Physician
_____ Address	_____ Address
_____ City, State, Zip	_____ City, State, Zip
_____ Phone and/or Fax Number	_____ Phone and/or Fax Number

Information to be released:

☐ Entire Record ☐ Lab Results ☐ Nursing Notes ☐ Demographics

☐ Emergency Room Notes ☐ Radiological Results ☐ Physician Orders ☐ Medication Admin Record

For dates of services rendered _____ through _____

For the purpose of: _____

I understand that I can revoke this authorization by providing written notice to the Health Information Department of St. Joseph's/Candler Physician Network at the address listed above or in a manner described in the Notice of Privacy Rights. I also understand that if information has been released by relying upon this Authorization, that revocation will not be valid.

I place no limitations on history of illness or diagnostic and therapeutic information, including any treatment for alcohol, drug abuse or dependency, psychiatric or psychological illness, mental illness or retardation and acquired immune deficiency (aids) syndrome.

The Entity listed above may not condition treatment, payment, on the signing of this authorization, unless allowed by law.

I understand that I am waiving my rights to privacy by releasing my medical information to the parties listed above and this information may be redisclosed by the receiving party. I hereby authorize the entity listed above to release the said information described above.

I understand that this Release of Information will expire within **NINETY (90) days** from the date listed below.

Patient Signature _____ **Date** _____

Patient's Guardian or Capacity _____ *Date* _____

Relationship to Patient _____

For Health Information Management Department Use Only:

Request taken by: _____ Date completed: _____

Method of Release: _____ Mail _____ Pick Up _____ Fax