St. Jude Medical Center
ST. JOSEPH HEALTH SYSTEM

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Completion of this document authorizes the disclosure and/or use of health information about you. Failure to provide all information requested may invalidate this Authorization.

EXPLANATION

This authorization is being requested of you to comply with the terms of the Confidentiality of the Medical Information Act of 1981, Civil Code Section 56 et seq. and the Health Insurance Portability and Accountability Act (HIPAA) of 2003.

Name of Patient:	
Date of Birth:	SSN:

USE AND DISCLOSURE OF HEALTH INFORMATION

I hereby Authorize St. Jude Medical Center to release my Medical Record to:

Name/Facility:	Attention:
Address:	Phone:
City: State: Zip:	FAX:

☐ Mail Copy To: (Address Above) ☐ Hold for Pick Up

☐ Normally we send paper copies; check box if you would like a thumb drive.

INFORMATION TO BE RELEASED (Only check one box in this section)

☐ Pertinent Information: (This is what most patients and physicians need)
Discharge Summary, History and Physical, Consultations, Operative Reports, Labs, Radiology, EEG, EMG, EKG, Pathology Reports.

OR ☐ All health information pertaining to my medical history, mental or physical condition

OR ☐ Only the following records or types of health information:

_____

_____

Specify the Date or Time Period For the Information Above:

AUTHORIZATION TO RELEASE STATUTORILY PROTECTED INFORMATION

I specifically authorize release of the following information (check and initial as appropriate):

☐ Mental health treatment information	Initial if requesting:
☐ HIV test results	Initial if requesting:
☐ Alcohol/drug treatment information	Initial if requesting:

A separate authorization is required to authorize the disclosure or use of psychotherapy notes.

PURPOSE

Purpose of requested use or disclosure:

☐ Patient Request ☐ Continuing Care ☐ Legal

☐ Insurance ☐ Other _____

101 E. Valencia Mesa Drive, Fullerton, CA 92835
Phone (714) 992-3940 Fax (714) 992-3098

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EXPIRATION

This Authorization expires [insert date]:_____
If no Date is given; this authorization will expire 6 months from the signature date.

MY RIGHTS

I may refuse to sign this Authorization. If I refuse to sign this Authorization, I should know that by law, my health information cannot be released. My refusal will not affect my ability to obtain treatment or payment or eligibility for benefits.

I may inspect or obtain a copy of the health information that I am being asked to allow the use or disclosure of.

I may revoke this authorization at any time, but I must do so in writing and submit it to the following address:

St. Jude Medical Center
Health Information Services-Correspondence
101 E. Valencia Mesa Drive
Fullerton, CA 92835

My revocation will take effect upon receipt, except to the extent that others have acted in reliance upon this Authorization.

I have a right to receive a copy of this Authorization.
Copy requested and received:

☐ Yes ☐ No	Initial:	Date:

Information disclosed pursuant to this authorization could be re-disclosed by the recipient. Such re-disclosure is in some cases not protected by California law and may no longer be protected by federal confidentiality law (HIPAA).

SIGNATURE

Patient Signature:	Date:
Legal Representative Signature: (Patient representative/spouse/financial responsible party)	Date:
If signed by someone other than the patient, state your legal relationship to the patient and why you have the authority to act for the patient:	
Witness Signature:	Date: