St. Claire HealthCare

# AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Patient Name: _____ Medical Record #: _____

Date of Birth: _____ Phone Number: _____ Social Security #: _____

1. **I hereby authorize** ☐ **St. Claire HealthCare OR** ☐ _____ **to disclose the health information, as described below, of the above named patient to:**

   Name: _____

   Address: _____

   City, State & Zip: _____

2. **Reason for request:**

   ☐ Personal Interest ☐ Insurance Claim Processing ☐ Legal Claim Processing

   ☐ Continuity of Care ☐ Social Security or Disability Claim ☐ Other (Specify) _____

3. **Type and amount of Information to be used or disclosed is as follows (include dates where appropriate):**

   ☐ Entire Medical Record ☐ History and Physical ☐ Pathology Report

   ☐ Emergency Room Record ☐ Operative Report ☐ Face Sheet

   ☐ Discharge Summary ☐ Other (Specify) _____

   ☐ Radiology Report (Specify Test & Date) _____

   ☐ Laboratory Reports (Specify Test & Date) _____

   Related to services provided during the following period of time: _____

   Information to be excluded from this authorization: _____

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), or records from other healthcare providers. It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse. **Initials:** _____

4. **The patient or the patient's representative must read the following statements:**

   A. I understand that this authorization will expire: ☐ 60 days from date of signature; OR

   ☐ upon the happening of the following events: _____

   B. I understand that I may revoke this authorization at any time. I also understand the Notice of Privacy Practices explains how I may revoke my authorization.

   C. I understand that authorizing the disclosure of this health information is voluntary, that I may refuse to sign this authorization and that I do not need to sign this form in order to ensure treatment.

   D. I understand that pursuant to KRS 304.17a-555-Patient's Rights of Privacy Regarding Mental Health or Chemical Dependency, my health information used under this authorization may not be shared again by the recipient of the information beyond the purpose of this authorization, without written consent to the redisclosure.

   E. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure by the recipient and may no longer be protected by federal confidentiality rules.

5. **I understand there may be a charge for this request and that I will be notified of the cost before any charges are incurred.**

6. **Records are routinely mailed. Personal ID is required with records are picked up (1 photo ID or 2 other forms of ID).**

   ☐ Social Security Card ☐ Drivers License ☐ School/Work ID ☐ Other (Specify) _____

_____ _____

Signature of Patient or Legal Representative Date

_____ _____

If Signed by Legal Representative, Relationship to Patient Signature of Witness

**The authorization must be signed by the patient if 18 years of age or over, or by a minor (under 18) if emancipated or otherwise eligible pursuant to KRS 214.185, or by the parent or legal guardian for any other minor or by patient's representative (i.e., power-of-attorney); or if the patient is deceased, by the executor or administrator. An order or letter of approval from the court is needed as proof for executor or administrator and a written document is needed as proof of power-of-attorney.**