SSM Medical Group

Request for Access to/Authorization for Use and Disclosure of Protected Health Information

PATIENT NAME:_____
LAST FIRST MI MAIDEN OR OTHER NAME

DATE OF BIRTH:_____-_____-_____
MO DAY YR

ADDRESS:_____ **CITY:**_____**STATE:**_____**ZIP:**_____

DAY PHONE:_____ **EVENING PHONE:**_____

I HEREBY AUTHORIZE:

NAME	
ADDRESS	
CITY, STATE & ZIP	
PHONE	
FAX	

TO DISCLOSE MY PROTECTED HEALTH INFORMATION TO:

NAME	
Relationship	
ADDRESS	
CITY, STATE & ZIP	
PHONE	
FAX	

METHOD OF DELIVERY OF RECORDS (*please select one*):
❑ Mail ❑ Hold for pick up by: _____

INFORMATION TO BE RELEASED	**CHECK TYPE**
Standard Record Release *Records within the last 2 years*	❑
Any and All Records *Includes records prior to the past 2 years*	❑
Discharge Summary	❑
History and Physical Exam	❑
Progress Notes	❑
Medication Records	❑
Detailed Bill	❑
Consult Notes	❑
Lab Reports	❑
X-Ray Reports	❑
Other: Specify Content and Dates	❑

I specifically authorize the release of information relating to:
☐ Substance Abuse (Including Alcohol/Drug Abuse
☐ Mental Health or Behavioral Health
☐ HIV Related Information/HIV Testing

_____
Signature of Patient or Legal Representative

_____
Date

PURPOSE OF DISCLOSURE:
❑ Changing Physicians ❑ Consultation ❑ Insurance/Workers' Compensation ❑ School ❑ Research
❑ Legal (specify): _____
❑ Other (specify): _____
❑ For personal access (specify): ❑ Copy ❑ Inspection ❑ Summary

ACKNOWLEDGEMENT OF UNDERSTANDING –*Please initial each line*

____I understand the expiration date of this authorization is ❑ _____ ❑ at end of research study; ❑ not applicable for ongoing research. (Authorization will expire 90 days from date signed unless otherwise stated)

____I understand that I may revoke this authorization at any time by notifying the providing organization in writing, and it will be effective on the date notified except to the extent action has already been taken in reliance upon it.

____I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by Federal privacy regulations.

____By authorizing this use or disclosure of information, there will be no conditions placed on my health care or payment for my health care.

____I understand that if I am being requested to authorize a use or disclosure that I will get a copy of this form after I sign it upon request.

____I understand my request will be acted upon within 30 days. If I am not provided access or information cannot be supplied, I understand I will be notified, and have the right to request review of any denial of access other than those made in accordance with applicable law.

____**I understand that I will be required to pay for the cost of preparing and mailing copies, supervising my inspection, or preparing a summary except for uses and disclosures for the purpose of treatment, payment, and operations. Quest Records is the business associate of SSM Medical Group. The fee paid to Quest Records will *not* exceed $20 per each disclosure request.**

PATIENT/LEGAL REPRESENTATIVE SIGNATURE: _____ _____ **DATE:** _____

RELATIONSHIP: _____