Saint Francis Health System

AUTHORIZATION TO USE OR SHARE PROTECTED HEALTH INFORMATION (PHI)

SAP 10049300 front / 05-10

FACILITY NAME AND ADDRESS

CHECK ONE BOX ONLY (Other Locations, Use Separate Form)

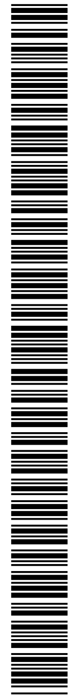
- ☐ Saint Francis Hospital ~ 6161 South Yale Avenue, Tulsa, OK 74136
- ☐ Saint Francis Hospital South ~ 10501 East 91st Street, Tulsa, OK 74133
- ☐ Laureate Psychiatric Clinic and Hospital
  6655 South Yale Avenue, Tulsa, OK 74136
- ☐ Other ______________________________

INDIVIDUAL INFORMATION (For Person Whose Information Will Be Shared)

PATIENT NAME IN FULL - *PRINT*	DATE OF BIRTH	MEDICAL RECORD NUMBER
STREET ADDRESS, CITY, STATE, ZIP CODE	PHONE NUMBER ( )	SOCIAL SECURITY NUMBER

SCOPE AND PURPOSE FOR SHARING INFORMATION

I understand protected health information is health care information that identifies me. The purpose of this authorization is to allow the Persons/Organizations as set forth above, to share my protected health information.



AUTHORIZATION AND INFORMATION TO BE SHARED

I authorize the Persons / Organizations as set forth below, to receive my protected health information for reasons in addition to those already permitted by law.

PERSONS / ORGANIZATIONS RECEIVING INFORMATION AND PURPOSE FOR SHARING

PERSON / ORGANIZATION	PHONE NUMBER ( )	RELATIONSHIP
ADDRESS	FAX NUMBER ( )	PURPOSE
PERSON / ORGANIZATION	PHONE NUMBER ( )	RELATIONSHIP
ADDRESS	FAX NUMBER ( )	PURPOSE
PERSON / ORGANIZATION	PHONE NUMBER ( )	RELATIONSHIP
ADDRESS	FAX NUMBER ( )	PURPOSE

INFORMATION TO BE SHARED

CHECK ONE OR MORE BOXES BELOW

- ☐ Pathology Report
- ☐ History and Physical
- ☐ Operation Report(s)
- ☐ Progress Notes
- ☐ Consultation Report(s)
- ☐ Discharge Summary
- ☐ EKG Report(s)
- ☐ Laboratory Report(s)
- ☐ Radiology Report(s)
- ☐ Physician's Orders
- ☐ Radiology Films
- ☐ Medication List
- ☐ Mental Health Records
- ☐ Other ______________________________
- ☐ Entire Medical Record (includes all records except Psychotherapy Notes or Alcohol or Drug Abuse Records)
- ☐ Alcohol or Drug Abuse Records (if checking this box, no other boxes may be checked)
- ☐ Psychotherapy Notes (if checking this box, no other boxes may be checked)

CHECK ONLY ONE OF THE BOXES BELOW

- ☐ Records covering services between (insert dates)

  ____________ and ____________ - OR - ☐ All Dates

COST FOR COPIES

First Page - **$1.00**

Each Subsequent Page - **$0.50**

Postage will be additional if mailing

CONTINUED ON REVERSE SIDE

HIPAA Document - Retain For a Minimum of 6 Years

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SAP 10049300 back / 05-10

PATIENT NAME IN FULL - *PRINT*

DATE OF BIRTH	MEDICAL RECORD NUMBER

EXPIRATION AND REVOCATION

This Authorization will expire - *MUST CHOOSE ONE:*

☐ 12 months from the date signed in the **SIGNATURES** section below

☐ Other (insert date or event) ____

Right to Revoke

I understand I may change this Authorization at any time by writing to the address of the facility identified on the front of this form. I understand I cannot restrict information that may have already been shared based on this Authorization.

ACKNOWLEDGEMENTS

I understand that this authorization is voluntary and will not affect my eligibility for benefits, treatment, enrollment, or payment of claims.

☐ If checked and initialed, ______________________________ is authorized to share my protected health information for the purpose of marketing. I understand ______________________________ may receive direct or indirect compensation for sharing my information in this case. Individual's initials ___________

I understand if the person/organization authorized to receive my protected health information is not a health plan or health care provider, privacy regulations may no longer protect the information.

I understand I may inspect or obtain a copy of the protected health information shared under this Authorization by sending a written request to the address of the facility identified on the front of this form.

I acknowledge information authorized for release may include records which may indicate the presence of a communicable or noncommunicable disease, including but not limited to diseases such as venereal disease, hepatitis, syphilis, gonorrhea and the human immunodeficiency virus, also known as Acquired Immune Deficiency Syndrome (AIDS).

SIGNATURES - This Document Must be Signed by the Individual or the Individual's Legal Representative

PATIENT SIGNATURE	DATE	TIME
SIGNATURE OF PERSON AUTHORIZED TO SIGN FOR PATIENT	DATE	TIME
PRINTED NAME OF PERSON AUTHORIZED TO SIGN FOR PATIENT	LEGAL CAPACITY / RELATIONSHIP TO PATIENT	
REASON PATIENT UNABLE TO SIGN		
WITNESS SIGNATURE	DATE	TIME

The following information may only be completed by ➔ **Provider / Facility checked on the top of the first page**

☐ If checked by ______________________________ — disclosure of Alcohol or Drug Abuse Records is subject to the following restrictions under 42 C.F.R Part 2:

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

TRANSLATION - This is to certify that the above Consent has been provided in printed format or read to the patient (or representative) in his/her native language. The patient (or representative) understood and agreed and was asked to sign the English version (legally valid document) and was shown where to indicate Consent.

INTERPRETER / WITNESS SIGNATURE

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