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

**PATIENT NAME** _____

**DATE OF BIRTH** ___/___/_____ **FORMER NAME** _____ **MEDICAL RECORD#** _____

**ADDRESS** _____ **CITY** _____ **STATE** ____ **ZIP** _____

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

Type of access requested: ☐ Inspection ☐ Hard Copy ☐ Electronic Copy **(only available if SSM Health maintains the requested information electronically)**

**I Hereby Authorize:**

| | |
|---|---|
| **NAME** | |
| **ADDRESS** | |
| **CITY/STATE/ZIP** | |
| **PHONE** | |
| **FAX** | |

**To Disclose My Protected Health Information To:**

| | |
|---|---|
| **NAME** | |
| **ADDRESS** | |
| ***Relationship*** | |
| **CITY/STATE/ZIP** | |
| **PHONE** | |
| **FAX** | |

## METHOD OF DELIVERY OF RECORDS *(please select one)*:

☐ Mail ☐ Hold for pick up by: _____

## INFORMATION TO BE RELEASED *(DATES)*:

☐ Discharge Summary _____
☐ History & Physical Exam _____
☐ Progress Notes _____
☐ Lab Reports _____
☐ X-Ray Reports _____
☐ Medication Records _____
☐ Detailed Bill _____
☐ 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 (AIDS related testing)

x _____

SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE / DATE

## PURPOSE OF DISCLOSURE:

☐ Changing physicians ☐ Consultation ☐ Insurance/Workers' Compensation ☐ School ☐ Research ☐ At request of individual
☐ Legal (specify): _____
☐ Other (specify): _____
☐ For personal access (specify): ☐ Copy ☐ Inspection ☐ Summary

## ACKNOWLEDGMENT OF UNDERSTANDING:

- 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 or State 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, upon request, I will get a copy of this form after I sign it.
- I understand my request will be acted upon within 30 days. If l 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 may be required to pay the cost of creating paper copies or electronic media, mailing copies

I acknowledge and understand the terms of this **Request for Access to/Authorization for Use and Disclosure of Protected Health Information**.

**Patient/Legal Representative Signature** _____ **DATE** _____

**Relationship** _____

**Records Received by** _____ **DATE** _____ **ID VERIFIED** _____