Health Information Management
Department
St. John's Medical Center
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Authorization to Release Medical Information

PATIENT INFORMATION (all must be completed):

Name: ____________________________ DOB: ______________________ Phone #: ___________________

Mailing Address: ____

*** Email: ____

1. INFORMATION RELEASED FROM:
   __ HOSPITAL
   __ PHYSICIAN OFFICE   DR: _________________________

2. INFORMATION DISCLOSED TO:
   Individual/Facility (name and address require below)   or ___ SELF
   ____ Phone # _______________________
   Mailing Address
   ____ Fax # __________________________
   ____

3. **REQUIRED: Dates of Service (last 6 months if not specified) From: __________ To: _____________ or______ OPEN**

4. INFORMATION TO BE RELEASED:
   ___ Emergency Room Record   ___ Lab/Blood/Pathology Reports   ___ Radiology Images
   ___ Inpatient Record   ___ Cardiopulmonary Records   ___ Billing Records
   ___ Outpatient Record   ___ Radiology Reports   ___ Physician Office Notes
   ___ Other: ____________________________________   ___ All Records

5. PURPOSE OF DISCLOSURE:
   ___ Personal Record   ___ Medical   ___ Insurance   ___ Legal   ___ Other

6. DELIVERY METHOD (please initial)
   ___ Pick Up by Self or Designee _____________________________ (ID required) ____ Mail ____ Fax
   ___ Email: __________________________

(Note the security of these transmissions cannot be controlled by SJMC)

In the event the facility is unable to accommodate an electronic delivery as requested, an alternative delivery method will be provided (e.g., papery copy). There is a risk that a third party could see your PHI without your consent when receiving by fax or email. Your signature below releases SJMC from liability for unauthorized access to the PHI contained in this format or any risks (e.g, virus) introduced to your computer/device when receiving PHI in electronic format or by fax. Please Note: Your records may contain sensitive data including sensitive test results like HIV and STD. The information used or disclosed pursuant to this authorization may be subject to re-disclosure and no longer be protected under federal law. You have the right to revoke this authorization in writing to the address above. The revocation will not affect any actions taken in reliance on this authorization before the receipt of the written revocation.

SENSITIVE DATA: I understand that my medical records may contain information concerning my mental health and/or psychiatric treatment, and I authorize their release unless denied by my treating physician. _____ I Do Not Authorize Release

This Authorization will expire 1 year from now unless one of these is initialed: ___One time disclosure ___ No expiration

Signature ____ Date:___________________