



- St. Vincent's Medical Center
- St. Luke's Hospital
- St. Catherine Laboure Manor

Authorization to Obtain Medical Information

Patient Name:	Birth Date:
Social Security # (last 4 digits only):	MMI #:
Address:	Telephone #:

I hereby authorize:

Organization/Person Name:	Telephone #:
Address:	Fax #:

To release the following medical information about me to:

Organization/Person Name:	Telephone #:
Address:	Fax #:

FOR THE FOLLOWING PURPOSE:

- Continued Care Social Security Disability Other _____
- Legal Reasons DCF
- Insurance Personal Use

Medical Information to be Released:

Psychotherapy Notes. (If you are requesting Psychotherapy Notes, then you may not release any other information with this authorization, and you may not check any of the other boxes in this section. To release your other records, you must submit a separate authorization.)

- History & Physical Laboratory Reports Emergency Department Record
- Discharge Summary Radiology Reports Other Medical Information _____
- Consultation Pathology Reports
- Operative/Procedure Report Anesthesia Record Complete Record (excluding Psychotherapy Notes, if any)

DATES OF SERVICE NEEDED: From _____ to _____
 All Dates of Service Last Visit Only

I understand that the released information may include information relating to the diagnosis, treatment and/or examination of alcohol and drug use; mental health (psychiatry/psychology/psychotherapy); HIV (Human Immunodeficiency Virus) and AIDS (Acquired Immune Deficiency Syndrome); and sexually transmissible diseases, and I specifically authorize the release of such information.

I acknowledge that I am signing this authorization voluntarily. St. Vincent's HealthCare and its affiliates will not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization. I understand that I may revoke this authorization in writing at any time, except to the extent already relied upon and except as stated in St. Vincent's HealthCare's Notice of Privacy Practices. To revoke this authorization, contact entity listed above in writing.

The law prohibits recipients of this information from using it for other than the stated purpose. The law also prohibits recipients from making any further disclosure of this information without the specific written consent of the patient. However, I understand that St. Vincent's HealthCare and its affiliates cannot guarantee that recipients of the information will not use or re-disclose it contrary to such legal prohibitions, and the information may no longer be protected by privacy laws once it has been so used or re-disclosed. The law prohibits the disclosure of mental health records to certain individuals in some circumstances, which may include patients and their family members. I hereby release St. Vincent's HealthCare and its affiliates, and their contractors and employees, from any and all liability that may arise from the release of information as I have directed.

This authorization expires twelve months from the date listed below and covers only dates of service for the dates specified above.

I have read and understand this authorization. I hereby authorize the release of the above-requested medial information about me.

Signature of Patient

Signature of Patient's Authorized Representative

Date

Description of Representative's Authority to Act for Patient

