



ST. VINCENT'S
MEDICAL CENTER
 St. Vincent's HealthCare

Authorization for Release of Medical Information

Patient Name: _____ Birth Date: _____

Address: _____ City: _____ State: _____

Social Security #: _____ Home Phone: _____ Alt. Phone: _____

I HEREBY AUTHORIZE:

Organization/Person Name: _____
 Address: _____ City: _____
 State: _____ Zip: _____ Phone #: _____ Fax #: _____

TO RELEASE THE FOLLOWING MEDICAL INFORMATION ABOUT ME TO:

St. Vincent's Family Medicine Center
2627 Riverside Ave. Jacksonville, FL 32204
Ph. (904) 308-7372 Fax (904) 308-2908

FOR THE FOLLOWING PURPOSE:

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

MEDICAL INFORMATION TO BE RELEASED:

Psychotherapy Notes (If you choose this box, then we may not release any other information with this Form and you may not check any of the following boxes in this section. To release other records, you must submit a separate authorization form.)

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

***Dates of Service needed: From _____ to _____
 All Dates of Service

FEE RATES: \$1.00 per page - paper records \$2.00 per page - micro film
 \$1.00 per year for each year of records requested

Note: Fee will be waived if released to treating Doctor/Treatment Facility.

- 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) and HIV (Human Immunodeficiency Virus) and AIDS (Acquired Immune Deficiency Syndrome.)
- I acknowledge that I am signing this authorization voluntarily. St. Vincent's 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 anytime, except to the extent already relied upon and except as stand in St. Vincent's Notice of Privacy Practices. Also, patients who believe information in their medical record is incorrect or incomplete may request an amendment of patient information. To revoke this authorization or request an amendment, contact St. Vincent's Privacy Office.
- The law prohibits recipients of this information without the specific written consent of the patient. However, I understand that St. Vincent's 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.
- 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 MEDICAL INFORMATION ABOUT ME.

 Signature of Patient

 Date

 Signature of Patient's Authorized Representative

 Description of Representative's Authority to act for Patient

 Witness