St. Elizabeth Medical Center

AUTHORIZATION TO OBTAIN / (USE OR DISCLOSE) PROTECTED HEALTH INFORMATION (PHI)

Authorization must be signed by the patient if age 18 or over; or by a minor patient (under 18) if emancipated or otherwise eligible pursuant to KRS214.185; or by parent or legal guardian for any other minor; or by the patient's legally authorized representative if the patient is otherwise unable to consent.

Request for medical information: ☐ **I am requesting information about myself.**

Patient name (at time of treatment) _____ _____Social Security Number _____

Date of Birth _____

Mailing address: _____

City _____ State_____ Zip Code: _____

Home Phone # (_____)_____ Work Phone # (_____)_____

☐ **I am requesting information about someone other than myself. Purpose**_____

My name _____My Social Security Number _____

Date of Birth_____

My Mailing address: _____

City _____ State_____ Zip Code: _____

Home Phone # (_____)_____ Work Phone # (_____)_____

My Relationship the Patient _____

The information I am requesting:

I am requesting a copy of the medical information which may include any and all hospital medical records, reports and information in the possession of St. Elizabeth Medical Center, including, without limitation, information concerning treatment of drug or alcohol abuse, drug-related conditions, psychiatric/psychological conditions and HIV/AIDS testing, diagnosis or treatment.

☐ I am requesting medical information for services provided: (attach additional pages if necessary)

Srvc. Date/Med. Rec#_____Information Requested_____

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☐ I hereby authorize _____ to disclose to: _____

Facility/Agency Name/ Title

_____ Phone

Agency/Hospital/Company (Home) _____

_____ (Work)_____

Address

_____

City/State

FEES - There are no charges for the first request of PHI in a 12-month period. For additional requests in the same 12-month period, the charge is 75 cents per page plus an additional $10 processing fee.

RESPONSE TIME - I understand that my request for PHI will be provided to me within 30 days (60 days for records that are stored off-site), unless I am notified in writing that an extension of up to 30 additional days will be needed.

_____ _____ _____

Signature of Patient/Authorized Representative Title Date

☐ **Identification validated** **Authorization Expiration Date** _____

(6 months unless otherwise indicated) Date

_____ _____ _____

Signature of Individual Releasing Information Department Date

NOTE: This authorization is valid for 6 months from the date of signature unless otherwise noted above. If you choose to revoke this authorization sooner, you must submit the request in writing to the Medical Record Department. The revocation will not apply to your insurance company when the law provides your insurer with the right to contest a claim under your policy. Any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. SEMC will not condition treatment or payment on the individual signing this authorization for use or disclosure of their health information.

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