St. Elizabeth HEALTHCARE

CONSENT

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

Originated: Medical Record | Revised: 09/08, 07/10, 04/12, 03/13 | File No.: CONSENT A-01 | Form No.: 9179 SEH

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 KRS 214.185 (See Consent Procedure); or by the parent or legal guardian for any other minor; or by the patient's legally authorized representative if the patient is otherwise unable to consent (See Consent Procedure).

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 to the Patient: _____

THE INFORMATION I AM REQUESTING:

I am requesting a copy of the medical information, which includes any and all hospital and medical record, reports, and information in the possession of St. Elizabeth Healthcare, 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: _____

Srvc. Date/Med. Rec #: _____ Information Requested: _____

Srvc. Date/Med. Rec #: _____ Information Requested: _____

❒ I hereby authorize _____ (Facility/Agency) to disclose to: _____ (Name & Title)

_____ (Agency/Hospital/Company) Phone: _____

_____ (Address) Home: _____

_____ (City/State) Work: _____

FEES – There are no charges for the first request of PHI in a 12-months period. For additional requests in the same 12 months period, the charge is $1.00 per page plus 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/Time

❒ Identification Validated | Authorization Expiration Date (6 months unless otherwise indicated): _____ Date/Time

_____ _____ _____

Signature of Individual Releasing Information | Department | Date/Time

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 Records 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 re-disclosure and the information may not be protected by federal confidentiality rules. SEHC will not condition treatment or payment on the individual signing this authorization for use or disclosure of their health information.

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