St.JosephHealth
St. Jude Medical Center

AUTHORIZATION FOR REQUESTING RECORDS FROM FACILITIES OUTSIDE OF ST. JUDE MEDICAL CENTER

Completion of this document authorizes the disclosure and/or use of health information about you. Failure to provide all information requested may invalidate this Authorization.

EXPLANATION

This authorization is being requested of you to comply with the terms of the Confidentiality of the Medical Information Act of 1981, Civil Code Section 56 et seq. and the Health Insurance Portability and Accountability Act (HIPAA) of 2003.

Name of Patient:	
Date of Birth:	SSN:

REQUESTING RECORDS FROM:

I hereby authorize:

Name/Facility:	Attention:
Address:	Phone:
City: State: Zip:	FAX:

To release my medical records to:

SENDING RECORDS TO:

St Jude Medical Center	Attention: Cardiac Rehabilitation
100 E. Valencia Mesa Drive Ste. 200	Phone: 714-992-3000 ext. 3789
Fullerton, CA 92835	FAX: 714-446-5345

INFORMATION TO BE RELEASED

☐ Pertinent Information: (This is what most patients and physicians need)
Discharge Summary, History and Physical, Consultations, Operative Reports, Heart Catheterization Report

_____

_____

Specify the Date or Time Period For the Information Above:

AUTHORIZATION TO RELEASE STATUTORILY PROTECTED INFORMATION

I specifically authorize release of the following information (check and initial as appropriate):

☐ Mental health treatment information	Initial if requesting:
☐ HIV test results	Initial if requesting:
☐ Alcohol/drug treatment information	Initial if requesting:

A separate authorization is required to authorize the disclosure or use of psychotherapy notes.

PURPOSE

Purpose of requested use or disclosure:

☐ Patient Request ☐ Continuing Care ☐ Legal
☐ Insurance ☐ Other _____

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EXPIRATION

This Authorization expires [insert date]:_____
If no Date is given; this authorization will expire 6 months from the signature date.

MY RIGHTS

I may refuse to sign this Authorization. If I refuse to sign this Authorization, I should know that by law, my health information cannot be released. My refusal will not affect my ability to obtain treatment or payment or eligibility for benefits.

I may inspect or obtain a copy of the health information that I am being asked to allow the use or disclosure of.

I may revoke this authorization at any time, but I must do so in writing and submit it to the address specified in the "REQUESTING RECORDS FROM" section above.

My revocation will take effect upon receipt, except to the extent that others have acted in reliance upon this Authorization.

I have a right to receive a copy of this Authorization.
Copy requested and received:

☐ Yes ☐ No	Initial:	Date:

SIGNATURE

Patient Signature:	Date:
Legal Representative Signature: (Patient representative/spouse/financial responsible party)	Date:
If signed by someone other than the patient, state your legal relationship to the patient and why you have the authority to act for the patient:	
Witness Signature:	Date:

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