SPOC8090

Patient Request for Release of Information

PATIENT NAME: _____ SSN#: _____ DOB: _____

HEALTHCARE PROVIDER: _____ Phone Number: _____

FILL OUT THIS SIDE IF RECORDS WILL BE RELEASED TO PATIENT OR PERSONAL REPRESENTATIVE:

I hereby request that the Healthcare Provider release the information outlined below to me.

METHOD OF DELIVERY:

☐ Pick Up
☐ E-mail records to me at:
_____
☐ Mail records to me at the following address:
_____
_____
_____
☐ Other: _____

FORMAT OF RECORDS:

☐ Paper
☐ Electronic

FILL OUT THIS SIDE IF RECORDS WILL BE RELEASED TO A THIRD PARTY:

I hereby request that Healthcare Provider release the information outlined below to:
Name: _____
E-mail: _____
Address: _____
_____

METHOD OF DELIVERY:

☐ Pick Up
☐ E-mail to email listed above
☐ Mail to address listed above
☐ Other: _____

FORMAT OF RECORDS:

☐ Electronic

INFORMATION TO BE RELEASED:

The type and amount of information to be used or disclosed is as follows: _____
Date(s) of service

☐ Entire medical record	☐ Progress notes	☐ Itemized statement
☐ History/physical	☐ Nurses notes	☐ Physician's orders
☐ Discharge summary	☐ Medication records	☐ Other (Please specify):
☐ Consultation report	☐ Laboratory results	_____
☐ Operative report	☐ X-ray results	_____

RELEASE FOR THE PURPOSE OF: _____

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

REVOCATION AND EXPIRATION

This authorization may be revoked at any time by my written consent except to the extent that action has already been taken in reliance thereon. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Privacy Officer (225 E. Washington Street, Jonesboro, AR 72401; (870) 207.4422). I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____. If I fail to specify an expiration date, event, or condition, this authorization will expire in 6 months.

FAILURE TO SIGN AUTHORIZATION

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that 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. If I have questions of my health information, I can contact the Privacy Officer at the above address and telephone number.

St. Bernards may not condition treatment, payment, enrollment or eligibility for benefits on whether you sign this authorization. Information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected under federal privacy law.

_____ _____
Signature of Patient or Personal Representative Date/Time

_____ _____
If signed by Personal Representative, Relationship to Patient SIgnature of Witness