THE BRADLEY CENTER OF ST. FRANCIS

MR# _____

Acct# _____

AUTHORIZATION: PRIVILEGED USE / DISCLOSURE OF PHI

***Please complete the following section** (print clearly)*

Patient's Last Name _____ First Name _____ MI _____

Birth Date *(Month/Day/Year)* _____

Street Address/Apt # *(Include Complete Mailing Address)* _____

Social Security Number _____

City _____ State _____ Zip _____

Home Phone # _____ Alternate Phone # _____

RELEASE INFORMATION TO *(Recipient of Use / Disclosure)*:

Name of Person or Organization Receiving Information _____

Telephone # _____

Street Address/Apt # *(Include Complete Mailing Address)* _____

Delivery Method: ☐ Pick up ☐ Mail ☐ CD / DVD

City _____ State _____ Zip _____

By signing this form, requestor understands that photocopy fees may apply at time of service, unless said copies are mailed directly to a health care provider.

Medical records requested date(s): ***From*** _____ ***To*** _____

Specific description of information to be used/disclosed:

☐ Psychotherapy Notes

☐ Other, specify: _____

I understand that this will include information relating to (check if applicable):

☐ Acquired immunodeficiency syndrome (AIDS) human immunodeficiency virus (HIV) infection

☐ Behavioral health service/psychiatric care

☐ Treatment for alcohol and/or drug abuse

This information is to be used for the following purposes: (check all that apply)

☐ Legal Issue ☐ Continuation of Care ☐ Other, explain: _____

☐ Insurance Claim ☐ Personal Use

I understand that the information used/disclosed pursuant to this authorization may be subject to redisclosure by the recipient of the information and, depending upon the applicability of federal privacy regulations, may then no longer be protected by those federal regulations. I understand that I may revoke this authorization in writing at any time by sending the revocation to the Release of information Office at St. Francis Hospital, Inc., except to the extent that St. Francis Hospital, Inc. has taken action in reliance on this authorization. I understand that I may refuse to sign this authorization and if I do, my information will not be used or disclosed for the purposes stated above. I understand that treatment provided by St. Francis Hospital, Inc. will not be conditioned upon my signature on this authorization. Unless otherwise revoked, this authorization will expire ninety (90) days from today's date and no further use/disclosure as described above may be made after such expiration.

Signature of Patient _____ **Signature of Authorized Personal Representative** _____

Date _____ **Print Name of Authorized Personal Representative** _____ **Relationship to Patient** _____

St.Francis

The Bradley Center of St. Francis Authorization for Disclosure of Health Information

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