St. Francis Medical Center
A Part of Verity Health

REQUEST FOR RELEASE OF MEDICAL RECORD INFORMATION

I REQUEST AND AUTHORIZE St. FRANCIS MEDICAL CENTER TO RELEASE INFORMATION FROM MY MEDICAL RECORD.

Patient Identification

Printed Name: _____ _____ Date of Birth: _____

Address: _____

_____

Social Security #:_____ Telephone: _____

Information To Be Released – Covering the Periods of Health Care

Treatment dates: _____

Please check type of information to be released:

☐ Discharge Summary	☐ Diagnosis & treatment codes	☐ Emergency Room record
☐ History and physical exam	☐ Consultation reports	☐ Progress notes
☐ Laboratory test results	☐ X-ray reports	☐ X-ray films / images
☐ Photographs, videotapes	☐ Complete billing record	☐ Itemized bill
☐ Complete health record	☐ Drug/Alcohol treatment **	☐ Psychiatric treatment **

** See below for additional verification of release request

☐ Other, (specify) _____

Purpose of Request

☐ Treatment or consultation	☐ At the request of the patient See information on charges	☐ Billing or claims payment

☐ Other, (specify) _____

Who and Where to Send / Release Information

Name: _____

Address: _____

_____

Time Limit & Right to Revoke Authorization

Except to the extent that action has already been taken in reliance on this authorization, at any time I can revoke this authorization by submitting a notice in writing to the facility Privacy Officer at St. Francis Medical Center 3630 E. Imperial Highway, Lynwood, CA 90262. Unless revoked, this authorization will expire on the following date or event _____, or one year from date of signature, unless otherwise specified.

Re-disclosure

I understand the information disclosed by this authorization may be subject to re-disclosure by the recipient and no longer be protected by the Health Insurance Portability and Accountability Act of 1996. The facility, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Drug and/or Alcohol Abuse, and/or Psychiatric, and/or HIV/AIDS Records Release

I understand if my medical or billing record contains information in reference to drug and/or alcohol abuse, psychiatric care, sexually transmitted disease, Hepatitis B or C testing, and/or other sensitive information, I agree to its release.
Check One: ☐ **Yes** ☐ **No**

I understand if my medical or billing record contains information in reference to HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome) testing and/or treatment I agree to its release.
Check One: ☐ **Yes** ☐ **No**

Signature of Patient or Personal Representative Who May Request Disclosure

I can inspect or copy the protected health information to be used or disclosed. **I authorize** St. Francis Medical Center **to use and disclose the protected health information specified above.**

Signature: _____ Date: _____

Authority to Sign if not patient: _____ Relation to patient:: _____

Identity of Requestor Verified via: ☐ **Photo ID** ☐ **Matching Signature** ☐ **Other, specify** _____

_____ Verified by: _____

I understand that I have a right to receive a copy of this authorization upon request, please initial below:

Not requested _____ Requested and received _____