SSMHealth | Medical Group

REQUEST FOR ACCESS TO/AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

PATIENT NAME: _____
LAST FIRST MI MAIDEN OR OTHER NAME

DATE OF BIRTH: ____-____-____ FORMER NAME: _____ MEDICAL RECORD #: _____
MO DAY YR

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

DAY PHONE: _____ EVENING PHONE: _____

I hereby authorize: **to disclose my protected health information as indicated below to:**

NAME: _____

ADDRESS: _____

CITY, STATE, ZIP: _____

PHONE: _____ FAX: _____

☐ Mail ☐ Hold for pick up by: _____

INFORMATION TO BE RELEASED:

I specifically authorize the release of information relating to:

☐ Substance abuse (including alcohol/drug abuse)

☐ Mental health or behavioral health

☐ HIV related information (AIDS related testing)

✗ _____
SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE DATE

DATES:

☐ Any and all records _____

☐ Discharge Summary _____

☐ History & Physical Exam _____

☐ Progress Notes _____

☐ Medication Records _____

☐ Detailed Bill _____

☐ Consult Notes _____

☐ Lab Reports _____

☐ X-Ray Reports _____

☐ Other (specify content and dates): _____

PURPOSE OF DISCLOSURE:

☐ Changing physicians ☐ Consultation ☐ Insurance/Workers' Compensation ☐ School ☐ Research ☐ At request of individual

☐ Legal (specify): _____

☐ Other (specify): _____

☐ For personal access (specify): ☐ Copy ☐ Inspection ☐ Summary

ACKNOWLEDGEMENT OF UNDERSTANDING:

Initial each line

____ I understand the expiration date of this authorization is ☐ _____ ☐ at end of research study; ☐ not applicable for ongoing research. (Authorization will expire 90 days from date signed unless otherwise stated)

____ I understand that I may revoke this authorization at any time by notifying the providing organization in writing, and it will be effective on the date notified except to the extent action has already been taken in reliance upon it.

____ I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by Federal privacy regulations.

____ By authorizing this use or disclosure of information, there will be no conditions placed on my health care or payment for my health care.

____ I understand that if I am being requested to authorize a use or disclosure that I will get a copy of this form after I sign it upon request.

____ I understand my request will be acted upon within 30 days. If I am not provided access or information cannot be supplied, I understand I will be notified, and have the right to request review of any denial of access other than those made in accordance with applicable law.

____ **I understand that I may be required to pay the cost of preparing and mailing copies, supervising my inspection, or preparing a summary except for uses and disclosures for the purpose of treatment, payment, and operations. Discovery Services is the business associate of SSM Physicians Organization. The fee will not exceed $20.00 per disclosure request.**

Patient/Legal Representative Signature: _____ DATE: _____ RELATIONSHIP: _____

Records Received by: _____ DATE: _____ ID VERIFIED: _____