Ascension St. Vincent's

Authorization for
Release of Medical Information
Medical Imaging Department

Patient Name:	**Birth Date:**	**CD ID: _____ Checked ID:** ☐ **** Staff sign/date: _____**
Address:		**MMI #:**
Telephone #		**SS# (last 4 digits ONLY):**

I HEREBY AUTHORIZE: _____ and its affiliates and agents
(Facility Name)

TO RELEASE THE FOLLOWING MEDICAL INFORMATION ABOUT ME TO:

Organization/Person Name:_____

Address:_____ Telephone #:___(_____)_____

City:_____State:_____ Zip:_____

FOR THE FOLLOWING PURPOSE:

☐ Continued Care ☐ Other _____

MEDICAL INFORMATION TO BE RELEASED:

☐ Radiology Reports ☐ Radiology Images ☐ Mammography/other breast images ☐ Other _____

DATES OF SERVICE NEEDED:

☐ Date From: _____ Date To: _____

☐ Exam Type _____

☐ All Dates of Service

- I understand that the released information may include information relating to the diagnosis, treatment, and/or examination of **ALCOHOL and DRUG USE**; **MENTAL HEALTH (psychiatry/psychology/psychotherapy)**; and **HIV (Human Immunodeficiency Virus) and AIDS (Acquired Immune Deficiency Syndrome)**.
- I acknowledge that I am signing this authorization voluntarily. St. Vincent's and its affiliates will not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this authorization.
- I understand that I may revoke this authorization in writing at anytime, except to the extent already relied upon and except as stated in St. Vincent's Notice of Privacy Practices. Also, patients who believe information in their medical record is incorrect or incomplete may request an amendment of patient information. To revoke this authorization or request an amendment, contact St. Vincent's Privacy Office.
- The law prohibits recipients of this information from using it for other than the stated purpose. The law also prohibits recipients from making any further disclosure of this information without the specific written consent of the patient. However, I understand that St. Vincent's and its affiliates cannot guarantee that recipients of the information will not use or re-disclose it contrary to such legal prohibitions, and the information may no longer by protected by privacy laws once it has been so used or re-disclosed.
- The law prohibits the disclosure of mental health records to certain individuals in some circumstances, which may include patients and their family members.
- This authorization expires twelve months from the date listed below and covers only dates of service for the dates specified above.

I have read and understood this authorization. I hereby authorize the release of the above-requested medical information about me.

_____ _____
Signature of Patient Signature of Patient's Authorized Representative

_____ _____
Date Description of Representative's Authority to Act for Patient

_____
Witness