Saint John's Health Center
Order of St. Benedict
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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Please Print

Patient	Name_____ Date of Birth_____ Address_____ Phone Number_____ City_____ State_____ Zip Code_____ Previous Name_____ Identification Number_____
Clinic/Hospital (who has the information you would like released?)	Name_____ Address_____ City_____ State_____ Zip Code_____ Phone Number_____ Fax Number_____
Requesting Party (send information to)	Name_____ Address_____ City_____ State_____ Zip Code_____ Phone Number_____ Fax Number_____
Information To Be Disclosed (only the information check marked will be released)	Date(s) of Service or Type of Service to be Released: Date:_____ to Date:_____ __History and Physical __Progress Notes __Pathology Reports __Outpatient Information __Consultation Reports __ER Reports __Laboratory Reports __EKG Reports __X-ray Reports __All Records __X-ray Films __Other
Special Disclosures	__Chemical Dependency __Psychiatric __HIV _____ to _____: concerning_____ Date Date Specific Diagnosis or Treatment
Revocation	I understand that I may revoke this authorization at any time with written notification. Revocation will not have any effect on the information released prior to notification of revocation. SJHC will not refuse or restrict my treatment if I choose not to sign this authorization. I realize that SJHC cannot prevent the redisclosure of records released as a result of this request and that the records may not be subject to privacy rule protections. Therefore SJHC is released from any and all liability resulting from redisclosure. I have read and understand my rights as described on this form.
Reason for Disclosure	__Continuing Care __Personal Use __Attorney __Insurance __Other (Specify)
Authorization	I authorize the above provider to release the information marked to the requester. _____ Patient/Guardian Signature Date _____ Relationship to Patient Reason Patient is Unable to Sign