



Trinity Health
Mid-Atlantic

St. Mary
Medical Center

☐ Checked ID _____
(First Initial, Last Name)

Authorization to Use or Disclose Health Information

Patient Name: _____ Phone #: _____

Date of Birth: _____ SS #: _____ Medical Record Number: _____

1. I authorize St Mary Medical Center to:

☐ Release Information to:

☐ Obtain Information from:

Individual or Facility _____

Address _____

Phone _____ Fax _____

2. The type of information to be used or disclosed is as follows: (check the appropriate boxes and include other information where indicated)

Date(s) of Service: _____

Face Sheet / Registration Sheet / Referral Sheet
Discharge Summary
ER Record
H&P
Consults
Progress Notes
Lab Results

Radiology Reports
EKG / Cardiology Testing Results
Operative Report
Pathology Report
Medication List
Entire Record (does not include the Extra Protected info listed in Section #3)
OTHER: please specify _____

3. Behavioral Health Information _____ Initial

Substance Abuse Information _____ Initial

Human Immunodeficiency Virus (HIV) Information _____ Initial

I understand that if my authorization includes Behavioral Health, substance abuse or HIV information, it may include; (i) information concerning whether an individual has been the subject of an human immunodeficiency virus (HIV) - related test, has HIV, an HIV related illness, acquired immunodeficiency syndrome (AIDS), and/or including information pertaining to the individual's contact (Section 7100.133); (ii) substance abuse information in my health record may include whether or not I am receiving treatment, my prognosis, a brief description of my progress, and/or a short statement as to whether I have relapsed into substance abuse and the frequency of such relapse (Pennsylvania Drug and alcohol abuse control act of 1972 - act 148 section 7(e); (iii) behavioral health information services. (Mental Health Procedures act 1976, section 5100.3-39).

4. This information for which I'm authorizing disclosure will be used for the following purpose:

Sharing with other health care providers as needed Other (please describe): _____

5. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the medical record department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

6. Unless I specify differently, this authorization will expire six months from the date signed below:

7. I understand that once the above information is disclosed, it may be redisclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

8. I understand that the use or disclosure of my health information is voluntary except in accordance with federal or state Law and any mandatory reporting requirements.

Signature of patient or legal representative _____ Date _____ Time _____

If signed by legal representative, relationship to patient _____

Signature of witness _____ Date _____ Time _____

A copy of this authorization form has been included with the copy of the medical record. I have been offered a copy of this Authorization Form: Accept / Refuse (Circle one and initial) _____