1465 South Grand Boulevard
St. Louis, MO 63104-1095
Fax Number: 314-268-6473

# 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:_____

**Type of access requested:** ❑ Inspection ❑ Hard Copy ❑ Electronic Copy (*only available if SSM Health maintains the requested information electronically)*

## I hereby authorize the following entity(s) to disclose/obtain my protected health information as indicated below:

❑ Cardinal Glennon Children's Hospital ❑ St. Joseph Hospital St. Charles ❑ St. Joseph Hospital-Wentzville ❑ DePaul Hospital ❑St. Clare Hospital

❑ St. Mary's Hospital St. louis ❑St. Joseph Hospital – Lake St. Louis ❑ Other_____)

**I Hereby Authorize:**

| | |
|---|---|
| **Name** | |
| **Address** | |
| **City, State, Zip** | |
| **Phone** | |
| **Fax** | |

**To Obtain from/Disclose to (circle one):**

| | |
|---|---|
| **Name** | |
| **Relationship** | |
| **Address** | |
| **City, State, Zip** | |
| **Phone** | |
| **Fax** | |

❑ Mail to the address above ❑ Hold for pick up ❑ E-Mail to the address below

**E-Mail Address:** __|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__@__|__|__|__|__|__|__ . __|__|__

**PROTECTED HEALTH INFORMATION TO BE RELEASED:**

- ❑ Discharge Summary Date(s):_____
- ❑ History & Physical Exam Date(s):_____
- ❑ Consultation Reports Date(s):_____
- ❑ Progress Notes Date(s):_____
- ❑ Lab Reports Date(s):_____
- ❑ Imaging Reports Date(s):_____
- ❑ Medication Records Date(s):_____
- ❑ Emergency Room Records Date(s):_____
- ❑ Other (specify content and dates):_____

I specifically authorize the release of information relating to:
- ❑ Genetic Testing
- ❑ Substance abuse (including alcohol/drug abuse)
- ❑ Mental health or behavioral health
- ❑ HIV related information (AIDS related testing)

X_____ _____
SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE DATE

**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:**

- I understand the expiration date of this authorization is ❑ _____ ❑ at end of research study; ❑ not applicable for ongoing research.
- 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 or State 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, upon request, I will get a copy of this form after I sign it.
- 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 creating paper copies or electronic media, mailing copies, supervising my inspection, or preparing a summary except for uses and disclosures for the purpose of treatment, payment, and operations.
- SSM Health believes that the only way to avoid third party interception of information sent through e-mail is to send such information by encrypted e-mail. Despite this warning about the risk that my protected health information could be read/intercepted by a third party if it is not sent by encrypted e-mail, I request SSM Health to send an electronic copy (if available) of the requested information by unencrypted e-mail.

I acknowledge and understand the terms of this **Request for Access to/Authorization for Use and Disclosure of Protected Health Information**.

Patient/Legal Representative Signature:_____ DATE:_____ Relationship:_____
Records Released by:_____ DATE:_____ ID VERIFIED:_____