SAINT FRANCIS
Hospital and Medical Center

Authorization to Obtain Health Information

Mount Sinai
Rehabilitation Hospital
a SAINT FRANCIS *Care* Provider

0980004

Patient Information

Patient Full Name: _____ Other Names During Treatment? _____

Patient Address: _____ Date of Birth: _____

City: _____ State: _____ Zip Code: _____ Phone #: _____

Release Information To

This box **must** *be complete in order for request to be processed*

I hereby authorize _____ to release information to:

Name / Facility: _____ Attention: _____

Address: _____ Phone #: _____

City: _____ State: _____ Zip Code: _____ Fax #: _____

Purpose of Request: ☐ Personal ☐Treatment ☐ Legal ☐ Insurance ☐ Disability
☐Transfer / Reason _____ ☐Other: _____

Information to be Released

Unless otherwise specified, only the following information will be released:

Inpatient/Same Day Abstract includes: History and Physical, Discharge Summary (Inpatient only), Reports of Consultations and Operative Reports when applicable

ED Abstract includes: ED MD Documentation and Nursing Notes **Clinic / Diagnostic Treatment Visit:** Note / Result from Date of Service

Behavioral Health Visit Abstract includes: Discharge Summary, Biopsychosocial Assessment, and Psychiatric Evaluation

☐ Please provide a 2 year abstract of my records
☐ Please provide my entire medical record for dates:
From: _____ To: _____
☐ Other – please be specific: include Clinic/Diagnostic treatment type and dates, ED Visit date, and / or Inpatient Dates of Admission

Comments

Authorization to Release Protected

***Required** – Please complete the check boxes below indicating how protected information should be handled even if the categories do not necessarily apply to the patient's medical records.

	Check one	Initial each line below
I	☐ **DO** ☐ **DO NOT** want information about ***Mental Health** released	_____
I	☐ **DO** ☐ **DO NOT** want information about ***HIV Tests & Related Information** released	_____
I	☐ **DO** ☐ **DO NOT** want information about ***Alcohol and/or Substance Abuse**	_____
I	☐ **DO** ☐ **DO NOT** want information about *_____ released	_____

"Other sensitive information? "

STOP

Please confirm that you have put a checkmark and initialed all the protected information categories above regardless if they are applicable or not. If form is incomplete, or if the protected information is not checked and initialed, we may be unable to fulfill this request.

Patient's Signature _____ **Date:** _____ **Time:** _____

(Required for all patients 18 years and older. 16 years and older for psychiatric records, 14 years and older for substance use records)

Signature of Parent or Legal Guardian: _____ **Date:** _____ **Time:** _____

(Required for all patients under the age of 18 unless otherwise allowed by law. If not the parent, legal representation documentation must be supplied)

- *This authorization will expire 180 days from the date appearing above . I understand that I may revoke this authorization at any time by notifying the Health Information Management Department in writing, but if I do, it will not have any effect on the actions the hospital took before it received the revocation.*
- *I understand that under the applicable law the information used or described pursuant to this authorization may be subject to redisclosure by the recipient and no longer subject to the protections of the privacy standard.*
- *I understand that my treatment or continued treatment by Saint Francis Hospital & Medical Center and its affiliates is no way conditioned on whether or not I sign the authorization and that I may refuse to sign it.*
- *I understand that I may inspect or copy the information that is used or disclosed.*