

ST. JOSEPH REGIONAL HEALTH NETWORK/ST. JOSEPH MEDICAL CENTER  
PO BOX 316, READING, PA 19603

**AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION**

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_/\_\_\_/\_\_\_  
Last First MI

Social Security #: \_\_\_\_-\_\_\_\_-\_\_\_\_ Daytime phone number: \_\_\_\_\_

Records requested from (check):

- St. Joseph Regional Health Network/St. Joseph Medical Center
- Other \_\_\_\_\_

Records requested by: \_\_\_\_\_

Requestor's address: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Identification obtained (check):

Dates of treatment to be released: \_\_\_\_\_

Type of reports requested (check):

- Pertinent information [recommended if requested by physician]
- ER Consultations  Lab, X-Ray and other tests
- Entire record  Discharge Summary
- Operative report  Other \_\_\_\_\_

Reason or purpose for the use or disclosure of the PHI (check):

- Continued care
- Attorney
- Personal
- Insurance company
- Other \_\_\_\_\_

Specific information to be released (check all that apply):

- Psychiatric illness
- Drug/ Alcohol treatment
- HIV testing/ diagnosis

\*\*\*This consent form will expire ninety (90) days after the date of signature or:

\_\_\_\_\_ specific date, event, or condition- date can be no longer than ninety (90) days

\*If authorization is for marketing, indicate if St. Joseph Regional Health Network/St. Joseph Medical Center will receive compensation in exchange for the use and/or disclosure of the PHI.

\_\_\_\_ YES \_\_\_\_ NO

**Prohibition on Conditioning of Authorization:** St. Joseph Regional Health Network/St. Joseph Medical Center will not condition treatment on your signing this authorization, unless:

- You are receiving research-related treatment; or
- The only reason the facility is providing you with health care is to make a report to a third party, such as your employer (e.g., fitness to return to work) or school (e.g., P.E. physical).

**Re-disclosure:** I understand that the information used and/or disclosed according to this authorization may no longer be protected by federal privacy law (also known as HIPAA) and the recipient of your health information may potentially redisclose it. However, under the Federal Substance Abuse Confidentiality Requirements, 42 CFR Part 2, the recipient may be prohibited from disclosing identifiable substance abuse information.

This consent is subject to revocation at any time, except to the extent that the organization which is to make the disclosure has already taken action in reliance on it. This information is being disclosed from records protected by federal regulation and Pennsylvania state law. Further disclosure of this information is prohibited, except with the written consent of the person to whom it pertains, or as otherwise permitted or authorized by the applicable state and federal laws and regulations. A general authorization is not sufficient for this purpose. I understand that there may be a charge incurred for processing this request including a per page copy fee, sales tax and shipping and handling expenses.

**This Authorization is Binding:** The statements made in this authorization are binding, controlling and I understand that they take precedence over statements made in the St. Joseph Regional Health Network/St. Joseph Medical Center's Notice of Privacy Practices.

Date: \_\_\_\_\_ Signature: \_\_\_\_\_  
Patient or legal representative  
Relationship: \_\_\_\_\_  
(if not patient signature)  
Date: \_\_\_\_\_ Signature: \_\_\_\_\_  
Witness

The client/patient or parent/guardian authorized to release information is physically unable to provide a signature consenting to the release of information. Verbal consent which indicates full understanding of the nature of this release has been given and witnessed.

Date: \_\_\_\_\_ Signature: \_\_\_\_\_  
Witness  
Date: \_\_\_\_\_ Signature: \_\_\_\_\_  
Witness

Was a signed copy provided to the individual: \_\_\_\_\_ YES \_\_\_\_\_ NO

rev. 04/13/00, 3/16/01, 6/26/03, 8/6/03

**SJH153**