Saint Anne's Hospital
A STEWARD FAMILY HOSPITAL
Steward

Authorization to Use and Disclose Protected Health Information

SAH REQUEST #_____ SAH MEDICAL RECORD #_____

1) I hereby authorize Saint Anne's Hospital to use or disclose the following protected health information from the medical records of the patient listed below. I understand that information used or disclosed pursuant to this authorization could be subject to redisclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.

2) PATIENT NAME:_____Date of Birth:_____
Please Print

Address:_____
Street City State Zip

Contact Telephone Number _____ __Social Security Number_____

3) DISCLOSE TO :

_____
Person or Facility (please print)

_____
Street (please print) City State Zip

Fax #_____

Phone #_____

4) TREATMENT DATES: From _____ to _____

Specific reports(s) to be released: (*complete restricted release section 5 if condition applies):*

☐Inpatient
☐Abstract
☐Face Sheet (registration sheet)
☐Discharge Summary
☐History and Physical
☐Consultation
☐Outpatient Reports
☐X-Ray
☐Laboratory
☐Pathology
☐Physical Therapy
☐Emergency Room
☐Other Specified _____
_____
_____

5) RESTRICTED RELEASE: By signing next to a category of highly confidential information listed below, I specifically authorize the use and/or disclosure pursuant to this Authorization.

Release	Signature	Release	Signature
☐Mental Health		☐Child /Elder Abuse and Neglect	
☐Developmental Disability		☐Rape / Sexual Abuse	
☐HIV/AIDS Testing, Results or Treatment		☐Abuse of an Adult with a Disability	
☐Sexually Transmitted Disease		☐Genetic Testing	
☐Alcohol and/or ☐ Drug		☐Social Worker Communication	

6) PURPOSE OF THE DISCLOSURE:

☐Medical Care ☐Legal ☐Insurance ☐Personal ☐Other_____
_____

7) REVOCATION: I understand that I may **revoke this authorization** at any time by requesting such of Saint Anne's Hospital in writing, unless action has already been taken in reliance upon it, or during a contestability period under applicable law.

8) TERM: This Authorization will remain in effect:

☐Until Saint Anne's Hospital fulfills this request.
☐From the date of this Authorization until the _____day of_____200____
☐Until the following event occurs:_____
☐Other:
_____

I understand that once Saint Anne's Hospital discloses my health information to the recipient, Saint Anne's Hospital cannot guarantee that the recipient will not re-disclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.

I understand that I may refuse to sign or may revoke (at any time) this Authorization for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of my treatment at Saint Anne's Hospital except, however, if my treatment at Saint Anne's Hospital is for the sole purpose of creating health information for disclosure to the recipient identified in this Authorization, in which case Saint Anne's Hospital may refuse to treat me if I do not sign this Authorization.

I understand that this Authorization will remain in effect until the term of this Authorization expires or I provide a written notice of revocation to Saint Anne's Hospital's Privacy Office at the address listed below. The revocation will be effective immediately upon Saint Anne's Hospital's receipt of my written notice, except that the revocation will not have any effect on any action taken by Saint Anne's Hospital in reliance on this Authorization before it received my written notice of revocation.

Access:
I understand that I have the right to access my Protected Health Information which is maintained by Saint Anne's Hospital in the Anne's Hospital's Designated Record Set upon completion of the Authorization to Use and Disclose Protected Health Information. I also understand I have the right to view and/or have copied my Protected Health Information in its entirety or an abstract. Based on State and Federal Law, Saint Anne's Hospital has a right to deny me access to all or portions of my Protected Health Information and must notify me in writing. I understand that Saint Anne's Hospital may charge a reasonable cost based fee associated with copying my Protected Health Information.

I may contact the Correspondence Department at: (508) 674-5741 extension 2218 or Fax (508) 675-5606.
I may contact Saint Anne's Hospital's Privacy Officer by mail at, HIM Department, Saint Anne's Hospital, 795 Middle Street, Fall River, MA 02721**,** or by telephone at **(**508) 235-5474**.**

I have read and understand the terms of this Authorization and I have had an opportunity to ask questions about the use and disclosure of my health information. By my signature below, I hereby, knowingly and voluntarily, authorize Saint Anne's Hospital to use or disclose my health information in the manner described above.

9)_____ **10)**_____
Signature of Patient **Date**

_____ ☐ **I.D**
Verification_____
Printed Name of Patient **Witness**

If the patient is a minor or is otherwise unable to sign this Authorization, obtain the following signatures:

9) _____ **10)**_____
Signature of Personal Representative **Date**

_____ **11)**_____
Printed name of Patient Representative **Relationship to patient or authority to act for patient**

Saint Anne's Hospital
Authorization to Request Protected Health Information

1) I hereby authorize the following to disclose the protected health information of the patient listed below. I understand that the information used or disclosed pursuant to this authorization could be subject to redislosure by the recipient, unless prohibited by law.

_____ , _____
Name of Facility or Person Address City State Zip Code

2) PATIENT NAME:_____Date of Birth _____
Please Print

Address:_____
Street City State Zip

Contact Telephone Number _____ Social Security Number_____

3) DISCLOSE TO:

☐ BY ELECTRONIC MEDIUM ☐ BY MAIL TO ADDRESS BELOW ☐ BY FAX TO FAX # BELOW

Type: _____ Department: _____ Attention: _____	Saint Anne's Hospital 795 Middle Street Fall River, MA 02721 Attention: _____	Saint Anne's Hospital Telephone #: _____ Fax #: _____ Attention: _____

4) TREATMENT DATES: From _____To _____

Specific reports(s)requested: (*complete restricted release section 5 if condition applies):*

☐In patient
☐Abstract
☐Face Sheet (registration sheet)
☐Discharge Summary
☐History and Physical
☐Consultation
☐Outpatient Reports
☐X-Ray
☐Laboratory
☐Pathology
☐Physical Therapy
☐Emergency Room
☐Other Specified _____
_____
_____

5) RESTRICTED RELEASE: By signing next to a category of highly confidential information listed below, I specifically authorize the use and/or disclosure pursuant to this Authorization.

Release	Signature	Release	Signature
☐Mental Health		☐Child/Elder Abuse and Neglect	
☐Developmental Disability		☐Rape / Sexual Abuse	
☐HIV/AIDS Testing, Results or Treatment		☐Abuse of an Adult with a Disability	
☐Sexually Transmitted Disease		☐Genetic Testing	
☐Alcohol and/or ☐ Drug		☐Social Worker Communication	

6) PURPOSE OF THE DISCLOSURE: ☐ Medical Care ☐ Other _____

7) REVOCATION: I understand that I may **revoke this authorization** at any time by requesting such of Saint Anne's Hospital in writing, unless action has already been taken in reliance upon it, or during a contestability period under applicable law.

8) TERM: ☐ Until fulfillment of this request. ☐ This authorization expires upon (specify date)_____

_____ _____
9) Signature of Patient or Legal Representative **10) Date**

_____ _____
(Printed name of patient or patient's representative) **11) Relationship**