SAINT JOHN'S
PHYSICIAN PARTNERS
PROVIDENCE

AUTHORIZATION TO USE, DISCLOSE & RELEASE PROTECTED HEALTH INFORMATION

I understand the following:

- I have the right to refuse to sign this form for authorization to disclose or release my protected health information. Refusal to sign the authorization will not adversely affect my ability to receive health care services or reimbursement for services. The only circumstance when refusal to sign this authorization may affect my ability to receive health care services is if the health care services are research-related or solely for the purpose of providing health information to someone else and the authorization is needed to make that disclosure.
- There may be a fee associated with this request.
- Information used or disclosed pursuant to this authorization may be subject to re-disclosure and no longer protected under federal law. However, I also understand that federal or state law may restrict re-disclosure of HIV/ AIDS, mental health information, genetic testing information and drug/alcohol diagnosis, treatment, or referral information.
- I have the right to receive a copy of this signed authorization.
- I may revoke this authorization in writing at any time. If I revoke this authorization, the information described below may no longer be used or disclosed for the purposes described in the written authorization. The only exception is when SJPP has taken action in reliance on the authorization or the authorization was obtained as a condition of insurance coverage.

To **revoke** this authorization, send a written statement that you are revoking this authorization along with a copy of this authorization to:

Release of Information Department
3460 Torrance Boulevard, Suite 310
Torrance, CA 90503
Phone: (310) 792-6333 Fax: (310) 792-6390

Saint John's Physician Partners no longer prints or releases patient social security numbers unless required for billing. However, social security numbers may be included in patient information that is more than a few years old. The information you are authorizing to be released may include your social security number.

The facility, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

*Once the completed medical records request is received by our administrative office, the expected turn around time is **10 business days** for completion.*

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I authorize Saint John's Physician Partners to use and disclose a copy of the specific health information described below regarding:

Patient's Name: _____ DOB: _____

Patient/Representative Name: _____ Phone: _____

To be disclosed to: (Name of Recipient(s)): _____

Recipient's Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

I am requesting information from the following facility(s):

Clinics Name (List) and Phone Number

For the ranges of dates from: _____ to: _____

For information related to the following diagnosis or injury: _____

Information to be disclosed:

☐ Progress Notes	☐ Immunizations	☐ Diagnostic Reports (lab, x-rays, EKG, etc.)
☐ Other (specify): _____		

For the purpose of: _____

Unless revoked, this authorization expires in 180 days or on this Date: _____

I understand and agree that the information below will be disclosed if I place my initials in the applicable space next to the type of information.

____ HIV/AIDS testing/treatment

____ Genetic Testing

____ Mental Health specific visits

____ Drug/Alcohol specific visits

Patient Signature: _____ Date: _____

Representative Name: _____ Date: _____

Representative Signature: _____ Relation to Patient: _____