ST. LOUISE REGIONAL HOSPITAL
A COMMUNITY HOSPITAL

REQUEST FOR RELEASE OF MEDICAL RECORD INFORMATION

I REQUEST/AUTHORIZE RELEASE OF INFORMATION FROM MY MEDICAL RECORD TO:

Organization/Person:_____ **Address** _____ **City** _____ **State**____ **Zip** _____ **Phone** _____ **Fax** _____	**O'Connor Hospital** 2105 Forest Avenue, San Jose, CA 95128 ☐ Medical Records ☐ RADIOLOGY ☐ OTHER _____

Patient Identification

Printed Name: _____ Date of Birth: _____

Address:_____

_____

Email:_____Telephone:_____

Information To Be Released: ☐ Mail ☐ CD ☐ Pick-up ☐ Review

Treatment dates: _____

Please check type of information to be released:

☐ Discharge Summary	☐ Emergency Room record
☐ History and physical exam	☐ Progress notes
☐ Laboratory test results	☐ X-ray images ☐ CD ☐ Copies
☐ Consultation reports	☐ X-ray / CT / MRI / ULT / NM reports
☐ Operative reports	☐ Complete health record (every page)
☐ EKG / Echo	☐ Psychiatric/drug/alcohol treatment **

** See next page for additional verification of release request

☐ Other, (specify)_____

Purpose of Request

☐ Treatment or consultation	☐ At the request of the patient. **There is a charge for this service.** $.25/page plus tax

☐ Other, (specify)

_____

See next page

Request for Release of Medical Record Info

Patient Name:_____

Time Limit & Right to Revoke Authorization

Except to the extent that action has already been taken in reliance on this authorization, at any time I can revoke this authorization by submitting a notice in writing to the facility Correspondence Staff, Medical Records Dept. Unless revoked, this authorization will expire on the following date or event _____, or one year from date of signature, unless otherwise specified.

Re-disclosure

I understand the information disclosed by this authorization may be subject to re-disclosure by the recipient and no longer be protected by the Health Insurance Portability and Accountability Act of 1996. 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.

Drug and/or Alcohol Abuse, and/or Psychiatric, and/or HIV/AIDS Records Release

I understand if my medical or billing record contains information in reference to drug and/or alcohol abuse, psychiatric care, sexually transmitted disease, Hepatitis B or C testing, and/or other sensitive information, I agree to its release. ***Check One:*** ☐ **Yes** _____ (init.) ☐ **No** _____ (init.)

I understand if my medical or billing record contains information in reference to HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome) testing and/or treatment I agree to its release.

Check One: ☐ **Yes** _____ (init.) ☐ **No** _____ (init.)

Signature of Patient or Personal Representative Who May Request Disclosure

I can inspect or copy the protected health information to be used or disclosed. **I authorize *O'Connor Hospital* to use and disclose the protected health information specified above.**

Signature: _____ Date: _____

Print Name: _____

Authority to Sign if not patient: _____ Relation to patient: _____

Identity of Requestor Verified via**:** ☐ **Photo ID** ☐ **Matching Signature**

☐ **Other, specify** _____ Verified: by: _____