CMC
CATHOLIC MEDICAL CENTER

AUTHORIZATION TO RELEASE OR REQUEST PROTECTED HEALTH INFORMATION

Please Check One:
- ☐ Pick Up: ___ Paper Copy ___ eCopy
- ☐ Mail
- ☐ Fax (to other providers only):_____

Patient Name: _____ Date of Birth: _____

Address: _____ Tel. No: _____

AUTHORIZATION TO: (Check One)

☐ *Release* Patient Information to: _____

Street: _____ City/State:_____

☐ *Request* Patient Information from: _____

Street: _____ City/State:_____

DATES OF SERVICE for patient information to be released or received: _____ to _____.

PATIENT INFORMATION to be released or received: (Check All That Apply)

☐ ED Visit ☐ Cardiac Testing ☐ Laboratory Tests ☐ Medical Images (report only) ☐ Office Notes

☐ Abstract (Discharge, Summary, History & Physical, Procedures, Consults, plus the above items).

☐ Other: (Please Specify) _____

SENSITIVE INFORMATION: (Please Initial)

Behavioral Health _____ HIV/AIDS _____ Drug or Alcohol* _____ Genetic Testing Results _____

PURPOSE for which this patient information is being requested/ released: (Check One)

☐ Continued Medical Care ☐ Transferring Out of Practice ☐ Other: (Please Specify) _____

- I understand that I may inspect or obtain a copy of the protected health information described by this Authorization.
- I understand that Catholic Medical Center shall not condition treatment on my providing authorization for the requested use or disclosure AND THAT I MAY REFUSE TO SIGN THIS AUTHORIZATION.
- I understand that this Authorization may be revoked in writing and the written revocation must be delivered to the Medical Records Department, revocation will not be effective for the disclosure of records whose release I had previously authorized, or where other action had been taken in reliance on a valid authorization.
- 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.
- I understand that it is my sole responsibility to safeguard any of my protected health information provided to me directly, and that Catholic Medical Center has not encrypted or otherwise protected any electronic media provided to me with my health information and shall not be liable for any subsequent acquisition, access, use or disclosure.

EXPIRATION DATE: This Authorization is valid until: (insert date/event) _____
(If no date/event is stated, this Authorization expires one year from the date it was signed.)

_____	___/___/___	____:____	_____
Signature of Patient or Representative	Date	Time	Relationship of Representative, if applicable

☐ COPY PROVIDED: If requested, CMC shall provide a copy of this signed Authorization to the subject individual.

***** This information has been disclosed to you from records whose confidentiality is protected by Federal confidentiality rules (42 C.F.R. Part 2). The Federal rules prohibit you from making any further disclose of this information without the specific written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any Alcohol or Drug abuse patient. (42 C.F.R. §2.32)