SAINT JOSEPH
Regional Medical Center

REQUEST FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Saint Joseph Regional Medical Center • Attn. Release of Information Department

☐ 5215 Holy Cross Parkway, Mishawaka, IN 46545 • Phone (574) 335-1452 • Fax (574) 335-1021
☐ 1915 Lake Avenue, Plymouth IN 46563 • Phone (574) 948-4980 • Fax (574) 948-5471
☐ 326 S. Chapin Street, South Bend, IN 46601 • Phone (574) 335-8222 • Fax (574) 335-0788
☐ 611 E. Douglas Rd. Suite 407, Mishawaka, IN 46545 • Phone (574) 335-6500 • Fax (574) 335-0772

PLEASE NOTE: ***ALL FIELDS MUST BE COMPLETED***

Patient Name:_____ DOB:_____ SS#: _____

Patient Address: _____ Phone: _____
Street Address City State Zip

I hereby authorize: _____
Name of Physician, Hospital, Agency

_____
Address (Street/City/State/Zip)

To release to: _____
Name of Physician, Hospital or Agency, or Self

_____
Address (City/State/Zip)

_____
E-mail address (if being released to self)

☐ Only the PHI minimally necessary, including all records regarding mental health/drug, alcohol treatment and/or HIV, AIDS or communicable disease information

OR

☐ The following specific portions or dates of service of my PHI:

❑ History and Physical ❑ Outpatient Therapy ❑ Other Test Results
❑ Discharge Summary ❑ Emergency Room Kinds: _____
❑ Operative Report ❑ Laboratory Tests _____
Other _____

From (date) _____ to (Date) _____

FOR THE PURPOSE OF: ❑ Self ❑ Attorney ❑ Other ❑ Continued Care ❑ Insurance

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I understand that the PHI may include information relating to mental health/drug, alcohol treatment and/or HIV, AIDS, or communicable disease.

It is understood that this authorization is subject to written revocation by me at anytime except for PHI that has already been released in response to this authorization. This authorization shall remain valid until revoked and will expire in 60 days or upon the following event or condition:_____

I understand that authorizing the disclosure of this PHI is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the PHI to be used or disclosed, as provided in 42 CFR 164.524. I understand that any disclosure of PHI carries with it the potential for an unauthorized re-disclosure and the PHI may not be protected by federal confidentiality rules.

_____ _____
Signature of Patient Signature of Other Authorized Person**

_____ _____
Date Signed Relationship of Other Authorized Person

**The signature of a parent (including a non-custodial parent provided that there are no court-ordered restrictions) or legal guardian is required for any unemancipated patient under the age of 18. A parent, guardian or custodian may sign for an incompetent patient. The personal representative of the estate may sign for a deceased patient; if no personal representative, the spouse may sign for a deceased patient; if no spouse or personal representative, an adult child may sign for the deceased patient.

Printing Instructions

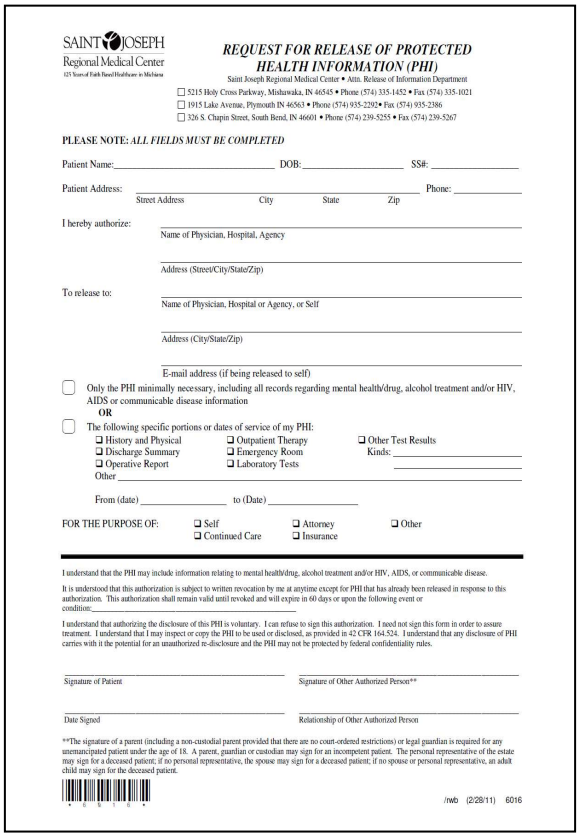
Title: Request for Release of Protected Health Information (PHI)

Entity: SJRMC

Printer Info: 20# White
Black ink
5 hole punch top
(Wound Healing Center in Mish needs 3 holes on side)

PDF File in Forms Directory

of pages: 1



SAINT JOSEPH Regional Medical Center
125 Years of Faith-Based Healthcare in Michiana

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☐ 1915 Lake Avenue, Plymouth IN 46563 • Phone (574) 935-2292 • Fax (574) 935-2386
☐ 326 S. Chapin Street, South Bend, IN 46601 • Phone (574) 239-5255 • Fax (574) 239-5267

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Street Address City State Zip

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Name of Physician, Hospital, Agency

_____
Address (Street/City/State/Zip)

To release to: _____
Name of Physician, Hospital or Agency, or Self

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/rwb (2/28/11) 6016