

5959 Park Avenue
Memphis, TN 38119
(901) 765-1981 phone
(901) 765-3269 or 765-3133 fax

2986 Kate Bond Road
Bartlett, TN 38133
(901) 820- 7630 phone
(901) 820-7631 fax

I, _____, do hereby authorize Saint Francis Healthcare

Or _____ to release to _____

Facility / Health Care Provider if other than Saint Francis Hospital

Agency or individual

Medical information relating to my treatment in said facility for the following purpose only:

The information released shall be limited to the following time period (s) or illness:

Include also the following specific type data (check all that apply):

- | | | |
|--|--|--|
| ☐ Abstract of Records | ☐ ER record | ☐ Radiology Film/CD |
| ☐ Discharge Data | ☐ EKG | ☐ Cardiology Film/CD |
| ☐ History & Physical | ☐ Lab | ☐ Billing Records/Financial Information |
| ☐ Operative Report | ☐ Complete Legal Medical Record | ☐ Other: _____ |
| ☐ X-Ray Report | | |

Expiration Date: The expiration date of this authorization is _____. If no expiration date or period is documented, it will expire **six (6) months** after the date recorded below.

This authorization covers only treatment prior to the date signed as recorded below.

I understand that I may revoke this authorization at any time with a written request to the Health Information Management Department of Saint Francis Healthcare. The request to revoke this authorization must contain the signature of the patient or the patient's legal representative.

Revocation of this authorization is allowable only to the extent that the release of information has not already occurred and/or only if the facility has not taken action in reliance thereon.

I understand that treatment, payment, enrollment or eligibility for benefits may not be conditioned on obtaining this authorization. **I further understand that any disclosure of records concerning diagnosis and/or treatment for alcohol or drug abuse is covered by Title 42 of the Code of Federal Regulations, and if there is any such information contain within, I hereby authorize the release of this information.**

Please initial below if appropriate:

_____ This authorization also includes any information related to diagnosis and/or treatment of any psychiatric or mental health, any state of infection with the HIV/AIDS virus or any other sexually transmitted diseases regardless of whether the results were positive or negative, Information about alcohol or drug abuse treatment program services, information about sexual assault, information about child abuse or neglect, or information regarding genetic testing.

Saint Francis Healthcare is hereby released from all legal liability that may arise from the release of the information requested. Please note that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected under applicable federal law. **For questions, please contact Saint Francis Healthcare Privacy Office by phone (901-820-7600, 901-765-2000) or at the above mentioned address.**

Signature of Patient or authorized Individual

Date

Relationship if signed by someone other than patient

Patient Social Security Number

Street Address

Phone Number

City, State, Zip Code

Date of Birth

Photo ID provided _____ yes _____ no

If no, the form of ID provided _____