AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

I, the undersigned, hereby authorize St. Vincent Neighborhood Hospital ("Hospital") to disclose/obtain the following identified Protected Health Information ("PHI"). Please check all that apply.

PATIENT INFORMATION

Name of Patient:	Date:
Maiden Name (if applicable):	
Date of Birth:	SSN:
Street Address:	
City, State, Zip Code:	Contact Phone Number:
Date of Treatment Requested:	

INFORMATION TO BE RELEASED (Limit request to the minimum necessary)

	Registration Record		Nurses Notes		Progress Notes
	Discharge Summary		Physician Orders		Radiology Report
	ER Report		Lab		
	History & Physical Report		Pathology Report		
	Other				

I understand that the PHI in my patient medical record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for drug and alcohol abuse.

RELEASE INFORMATION TO (If not the Patient)

Name:
Address:
City, State, Zip Code:
Purpose for disclosure:

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to St. Vincent Neighborhood Hospital, P.O. Box 61630, Houston, TX 77208, Attn: HIM Department. I understand that a revocation is not effective to the extent that Hospital has relied on the use of disclosure of the PHI. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

I understand that this authorization will expire in sixty (60) days unless otherwise specified.

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

Hospital will not condition my treatment, payment, or enrollment (if applicable) in a health plan or eligibility for benefits on whether I provide authorization for the requested use or disclosure.

I understand that I have the right to refuse to sign this authorization.

By signing this authorization, I acknowledge that I have read and understand this authorization. Further, I authorize the use or disclosure of my PHI in accordance with the terms of this authorization.

Signature of Patient, Guardian, Parent, or Health Representative:
Relationship to Patient, if other than Patient:

You may mail or fax this completed form with a copy of photo identification to:
St. Vincent Neighborhood Hospital
P.O. Box 61630
Houston, TX 77208
Fax: 1-866-231-6986
Phone: 1-855-490-1807

St. Vincent NEIGHBORHOOD HOSPITAL