Address form to: **HEALTH INFORMATION**
6161 South Yale Avenue
Tulsa, OK 74136-1902
Fax: 918-494-1737

SaintFrancis Health System

AUTHORIZATION TO RELEASE FACILITY'S PROTECTED HEALTH INFORMATION (PHI)

SAP 10049300 front / 08-17

FACILITY NAME ~ CHECK ONE BOX ONLY (Other Locations, Use Separate Form)

- ☐ Saint Francis Hospital ~ 61st & Yale, Tulsa, OK
- ☐ Saint Francis Hospital South ~ 91st & Hwy 169, Tulsa, OK
- ☐ Saint Francis Hospital Vinita ~ Vinita, OK
- ☐ Saint Francis Hospital Muskogee, Muskogee, OK
- ☐ Laureate Psychiatric Clinic and Hospital ~ 66th & Yale, Tulsa, OK
- ☐ Saint Francis Home Health and Hospice, Tulsa, OK
- ☐ Other _____

INDIVIDUAL INFORMATION (Person Whose Information Will Be Released)

PATIENT NAME IN FULL - *PRINT*	DATE OF BIRTH	MEDICAL RECORD NUMBER
STREET ADDRESS, CITY, STATE, ZIP CODE	**PHONE NUMBER**	**SOCIAL SECURITY NUMBER**
	( )	

AUTHORIZATION AND INFORMATION TO BE RELEASED

I authorize the Persons / Organizations as set forth below, to receive my protected health information for reasons in addition to those already permitted by law.

PERSONS / ORGANIZATIONS RECEIVING INFORMATION AND PURPOSE FOR RELEASING

PERSON / ORGANIZATION	PHONE NUMBER	RELATIONSHIP
	( )	
ADDRESS	**FAX NUMBER**	**PURPOSE**
	( )	
PERSON / ORGANIZATION	PHONE NUMBER	RELATIONSHIP
	( )	
ADDRESS	FAX NUMBER	PURPOSE
	( )	
PERSON / ORGANIZATION	PHONE NUMBER	RELATIONSHIP
	( )	
ADDRESS	FAX NUMBER	PURPOSE
	( )	

INFORMATION TO BE RELEASED

CHECK ONE OR MORE BOXES BELOW

- ☐ Pathology Report
- ☐ History and Physical
- ☐ Operation Report(s)
- ☐ Progress Notes
- ☐ Consultation Report(s)
- ☐ Discharge Summary
- ☐ EKG Report(s)
- ☐ Laboratory Report(s)
- ☐ Radiology Report(s)
- ☐ Physician's Orders
- ☐ Radiology Films
- ☐ Medication List
- ☐ Mental Health
- ☐ Alcohol / Drug Abuse
- ☐ Psychotherapy Notes ***(no other boxes may be checked)***
- ☐ Entire Medical Records (except psychotherapy notes)
- ☐ Other _____

DATES OF INFORMATION TO BE RELEASED

CHECK ONLY ONE OF THE BOXES BELOW

☐ Records covering services between (insert dates) _____ and _____

- OR -

☐ All Dates, Including Future Dates

☐ All Dates, But **NOT** Future Dates

COST FOR PAPER COPIES

Each Page - **$0.50 -** *Postage will be additional if mailing*

COST FOR DIGITAL FORMAT

$0.30 Per Image *(not to exceed a total of $200)*

COST FOR X-RAY OR OTHER IMAGE

$5.00 Per Image

ADDITIONAL COSTS

- Attorney, Insurance & Subpeona Requests
- Postage or Delivery cost

+ $10.00

SaintFrancis Health System

AUTHORIZATION TO RELEASE FACILITY'S PROTECTED HEALTH INFORMATION (PHI)

SAP 10049300 back / 08-17

PATIENT NAME IN FULL - *PRINT*

DATE OF BIRTH	MEDICAL RECORD NUMBER

EXPIRATION AND REVOCATION

This Authorization will expire - *MUST CHOOSE ONE:*

☐ 12 months from the date signed in the **SIGNATURES** section below

☐ Other (insert date or event) _____

Right to Revoke

I understand I may change this Authorization at any time by writing to the address of the facility identified on the front of this form. I understand I cannot restrict information that may have already been released based on this Authorization.

ACKNOWLEDGEMENTS

I understand that this authorization is voluntary and will not affect my eligibility for benefits, treatment, enrollment, or payment of claims.

☐ If checked and initialed, the Facility is authorized to release my protected health information for the purpose of marketing.

I understand the Facility may receive direct or indirect compensation for releasing my information in this case.

Individual's initials _____

I understand if the person/organization authorized to receive my protected health information is not a health plan or health care provider, privacy regulations may no longer protect the information.

I understand I may inspect or obtain a copy of the protected health information shared under this Authorization by sending a written request to the address of the facility identified on the front of this form.

I acknowledge information authorized for release may include records which may indicate the presence of a communicable or noncommunicable disease, including but not limited to diseases such as venereal disease, hepatitis, syphilis, gonorrhea and the human immunodeficiency virus, also known as Acquired Immune Deficiency Syndrome (AIDS).

SIGNATURES - This Document Must be Signed by the Individual or the Individual's Legal Representative

PATIENT SIGNATURE	DATE	TIME

SIGNATURE OF PERSON AUTHORIZED TO SIGN FOR PATIENT	DATE	TIME

PRINTED NAME OF PERSON AUTHORIZED TO SIGN FOR PATIENT	LEGAL CAPACITY / RELATIONSHIP TO PATIENT

REASON PATIENT UNABLE TO SIGN

WITNESS SIGNATURE	DATE	TIME

Re-Disclosure of Alcohol or Drug Abuse Records is subject to the following restrictions under 42 CFR Part 2:

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR 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.

TRANSLATION - This is to certify that the above Authorization has been provided in printed format or read to the patient (or representative) in his/her primary language. The patient (or representative) understood and agreed and was asked to sign the English version (legally valid document) and was shown where to indicate acceptance.

INTERPRETER / WITNESS SIGNATURE

DATE	TIME