Saint Francis Hospital - Memphis
5959 Park Avenue
Memphis, TN 38119
HIM RELEASE OF INFORMATION
Phone 901-765-1981 Fax 901-765-3269

MR#
Account #

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

PATIENTS NAME: DATE OF BIRTH: ADDRESS:
CITY: STATE: ZIP:
PHONE NUMBER: LAST 4 DIGITS OF SSN: DATE OF REQUEST:

□ I WOULD LIKE TO REQUEST A PAPER COPY OF THE HEALTH INFORMATION CHECKED BELOW
(***Check all that apply***) *-- As a courtesy for choosing Saint Francis as your hospital of choice, you will receive up to ten pages at no cost*

□ **Abstract of medical record** (*history & physical, discharge summary, operative report, test results*)		
□ **History and Physical**	□ **Discharge Summary**	□ **Consultation**
□ **Radiology & Diagnostic reports**	□ **Lab Results**	□ **Operative Report**
□ **Consultation**	□ **ER Record**	□ **Pathology report**
□ **EKG**	□ **Cardiac Cath Report**	□ **Complete legal medical record (additional cost)**
□ **Other**		
DATES OF SERVICE FOR INFORMATION SELECTED ABOVE - *ONLY LISTED DATES ARE AUTHORIZED FOR RELEASE*		

EXPIRATION OF AUTHORIZATION
Unless otherwise revoked, this Authorization expires on _____ (insert applicable date or event). If no date indicated, this authorization will expire 12 months after the date of signed authorization below.

□ I AUTHORIZE SAINT FRANCIS HOSPITAL TO RELEASE PHI TO:

_____
Name of person/facility to receive PHI ***Phone or fax#***

_____
Address: ***City*** ***State*** ***Zip***

Please Initial:

_____ **I UNDERSTAND** that I may revoke this authorization at any time, with a written request to the Health Information Management Department at Saint Francis Hospital. 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 any disclosure of patient's personal health information may include information regarding diagnosis and/or treatment for any of the following: alcohol abuse, drug abuse, psychiatric or mental illness, and/or sexually transmitted diseases including Human Immunodeficiency Virus (HIV) or (AIDS virus).

Saint Francis Hospital 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 HIPAA laws and regulations.
For questions and concerns, please contact the Health Information Management Department at 901-765-1981.

NOTE: All personnel with access to Tenet electronic systems are prohibited from viewing any records electronically for personal use. This form must be complete with approval from the HEALTH INFORMATION MANGEMENT DEPARTMENT to receive a paper copy of your personal record. Please see Tenet policy HR.ERW.14, "Corrective, Remedial, and Disciplinary Action for Violation of Compliance Standards" & EC.PS.02.00, "Patient information privacy policy". Viewing any patient records electronically is only acceptable if accessing the record(s) is within the normal course of business and within the scope of your regular job duties.

_____ _____
SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE DATE OF AUTHORIZATION

_____ **Photo ID provided_____yes_____no**
RELATIONSHIP AND/OR AUTHORITY TO ACT FOR THE PATIENT **If no, the form of ID provided_____**