ST JOSEPH HEALTH SYSTEM

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Completion of this document authorizes the disclosure and/or use of health information about you. Failure to provide all information requested may invalidate this Authorization.

Note: If you are a patient requesting records for yourself; there will be an additional charge. Please see the attached Patient Access Cover Sheet or call (714)-992-3940.

EXPLANATION

This authorization is being requested of you to comply with the terms of the Confidentiality of the Medical Information Act of 1981, Civil Code Section 56 et seq. and the Health Insurance Portability and Accountability Act (HIPAA) of 2003.

Name of Patient:	
Date of Birth:	SSN:

USE AND DISCLOSURE OF HEALTH INFORMATION

I hereby Authorize **St. Jude Medical Center** to release my Medical Record to:

Name/Facility: Hoosier Services Inc.	Attention:
Address: 18032 Lemon Dr., #C-618	Phone: 800.882.4156
City: Yorba Linda State: CA Zip: 92886	FAX: 800.882.4957

[X] Mail Copy To: (Address Above) [ ] Hold for Pick Up

[X] Normally we send paper copies; check box if you would like a thumb drive instead.

INFORMATION TO BE RELEASED

[ ] All health information pertaining to my medical history, mental or physical condition

OR [ ] Pertinent Information: Discharge Summary, History and Physical, Consultations, Operative Reports, Labs, Radiology, EEG, EMG, EKG, Pathology Reports.

OR [ ] Only the following records or types of health information:

_____

_____

Specify the Date or Time Period For the Information Above:

AUTHORIZATION TO RELEASE STATUTORILY PROTECTED INFORMATION

I specifically authorize release of the following information (check and initial as appropriate):

[ ] Mental health treatment information	Initial if requesting:
[ ] HIV test results	Initial if requesting:
[ ] Alcohol/drug treatment information	Initial if requesting:

A separate authorization is required to authorize the disclosure or use of psychotherapy notes.

PURPOSE

Purpose of requested use or disclosure:

[ ] Patient Request [ ] Continuing Care [ ] Legal

[X] Insurance [ ] Other _____

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EXPIRATION

This Authorization expires [insert date]:_____
If no Date is given; this authorization will expire 6 months from the signature date.

MY RIGHTS

I may refuse to sign this Authorization. If I refuse to sign this Authorization, I should know that by law, my health information cannot be released. My refusal will not affect my ability to obtain treatment or payment or eligibility for benefits.

I may inspect or obtain a copy of the health information that I am being asked to allow the use or disclosure of.

I may revoke this authorization at any time, but I must do so in writing and submit it to the following address:

St. Jude Medical Center
Health Information Services-Correspondence
101 E. Valencia Mesa Drive
Fullerton, CA 92835

My revocation will take effect upon receipt, except to the extent that others have acted in reliance upon this Authorization.

I have a right to receive a copy of this Authorization.
Copy requested and received:

☐ Yes ☐ No	Initial:	Date:

Information disclosed pursuant to this authorization could be re-disclosed by the recipient. Such re-disclosure is in some cases not protected by California law and may no longer be protected by federal confidentiality law (HIPAA).

SIGNATURE

Patient Signature:	Date:
Legal Representative Signature: (Patient representative/spouse/financial responsible party)	Date:
If signed by someone other than the patient, state your legal relationship to the patient and why you have the authority to act for the patient:	
Witness Signature:	Date:

St. Jude Medical Center
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PATIENT RECORDS REQUEST

BACTES Imaging Solutions is the copy service for St. Jude Medical Center. If you are requesting a copy of your medical records there will be a charge of $0.25 (25 cents) per page.

- **Note:** If your record is less than 20 pages your request will be free of charge.
- For records greater than 20 pages, once your request has been processed you will be invoiced by BACTES Imaging solutions.
- Upon receipt of payment; BACTES will send you your records.

PATIENT CONTACT INFORMATION	
Name of Patient:	
Daytime Phone#:	
☐ Mail Copies To Address on Authorization	☐ Hold for Pick Up

CALIFORNIA CIVIL CODE 123110

California Patient Access to Health Records. Inspection and copying; Paragraph (b): Additionally, any patient or patient's representative shall be entitled to copies of all or any portion of the patient records that he or she has a right to inspect, upon presenting a written request to the health care provider specifying the records to be copied, together with a fee to defray the cost of copying, that shall not exceed twenty five cents ($0.25) per page or fifty cents ($0.50) per page for records that are copied from microfilm and any additional reasonable clerical costs incurred in making the records available.

WHEN WILL MY RECORDS BE READY?

Your records will be mailed or ready for pick up in less than 10 days from the receipt of your request. Should you have any questions, please call BACTES customer service at 800-560-3800.

BACTES Imaging Solutions
www.bactes.com (800) 560-3800

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