Saint Francis Physician Network, LLC
6005 Park Ave Suite 325B MEMPHIS, TN 38119-5211
Office: (901) 765-2243 Fax: (844) 630-9772

RECORD RELEASE or REQUEST/ AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION

FAX REQUESTS TO (844) 630-9772

Patient's Name: ____ Date of Birth: _______________
First Middle Last

Home Address: ____ Home Telephone: ___________________________

SPECIFY INFORMATION TO BE RELEASED OR REQUESTED (CIRCLE WHICH): The information that may be released or requested (circle which) under this Authorization includes:

☐Discharge Summary ☐Progress/Physician Notes ☐X-Ray Report ☐Pathology Report
☐History & Physical ☐Nurses Notes ☐EKG/EMG/EEG Report ☐Consult Report
☐Emergency Report ☐Laboratory Report ☐Operative Report ☐Entire Record
☐Other: ____
Records for the period (dates) from ______________ to ______________

MY HIGHLY CONFIDENTIAL INFORMATION:

By checking any of the boxes next to a category of highly confidential information listed below, I specifically authorize the use and/or disclosure of the category of highly confidential information indicated next to the box, if any such information will be used or disclosed pursuant to this Authorization:

☐ Information about mental health or mental retardation services
☐ Psychotherapy Notes created by a mental health professional
☐ Information about HIV/AIDS-related testing (including the fact that an HIV test was ordered, performed or reported, regardless of whether the results of such tests were positive or negative)
☐ Information about sexually transmitted diseases
☐ Information about alcohol or drug abuse treatment program services
☐ Information about sexual assault
☐ Information about child abuse and neglect

☐ **RELEASE Information To:** ______________________________ Name:	☐ **RELEASE Information From:** ______________________________ Name:
Address:	Address:
City, State, Zip:	City, State, Zip:
Telephone: Fax:	Telephone: Fax:

TERM: This Authorization will remain in effect:

☐ From the date of this Authorization until the _____ day of _______, 20____.
☐ Until SAINT FRANCIS PHYSICIAN NETWORK, LLC fulfills this request.
☐ Until the following event occurs: ____
☐ Other: ____

PURPOSE: I authorize SAINT FRANCIS PHYSICIAN NETWORK, LLC to use or disclose my health information (including the highly confidential information I selected above, if any) during the term of this Authorization for the following specific purpose(s): [Note: “at the request of the Patient” is sufficient if the Patient is initiating this Authorization]

RECORD RELEASE / AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION

I understand that once SAINT FRANCIS PHYSICIAN NETWORK, LLC discloses my health information to the recipient, SAINT FRANCIS PHYSICIAN NETWORK, LLC cannot guarantee that the recipient will not redisclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.

I understand that SAINT FRANCIS PHYSICIAN NETWORK, LLC may, directly or indirectly, receive remuneration from a third party in connection with the use or disclosure of my health information.

I understand that I may refuse to sign or may revoke (at any time) this Authorization for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of my treatment at SAINT FRANCIS PHYSICIAN NETWORK, LLC; except, however, if my treatment at SAINT FRANCIS PHYSICIAN NETWORK, LLC is for the sole purpose of creating health information for disclosure to the recipient identified in this Authorization, in which case SAINT FRANCIS PHYSICIAN NETWORK, LLC may refuse to treat me if I do not sign this Authorization.

I understand that this Authorization will remain in effect until the term of this Authorization expires or I provide a written notice of revocation to SAINT FRANCIS PHYSICIAN NETWORK, LLC’s Privacy Office at the address listed below. The revocation will be effective immediately upon SAINT FRANCIS PHYSICIAN NETWORK, LLC’s receipt of my written notice, except that the revocation will not have any effect on any action taken by SAINT FRANCIS PHYSICIAN NETWORK, LLC in reliance on this Authorization before it received my written notice of revocation.

I understand that there may be a charge for producing record copies according to state regulations.

I may contact SAINT FRANCIS PHYSICIAN NETWORK, LLC’s Privacy Office at:

Corporate Compliance & Privacy Office
Tenet Healthcare
1445 Ross Avenue, Suite 1400
Dallas, Texas 75202
E-mail:PrivacySecurityOffice@tenethealth.com
Ethics Action Line (EAL) 1-800-8-ETHICS

I have read and understand the terms of this Authorization and I have had an opportunity to ask questions about the use and disclosure of my health information. By my signature, I hereby, knowingly and voluntarily authorize SAINT FRANCIS PHYSICIAN NETWORK, LLC to use or disclose my health information in the manner described above.

Signature ______________________________________

Date ______________________________________

Note: if Patient is a minor or is otherwise unable to sign this Authorization, obtain the following signatures.

Signature of Authorized Personal Representative ______________________________________

Relationship to Patient ______________________________________

Date ______________________________________