



# ST. JOSEPH

Regional Medical Center  
415 6th Street ~ P.O. Box 816  
Lewiston, Idaho 83501

Patient Name: \_\_\_\_\_  
Birth Date: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone Number: \_\_\_\_\_  
Medical Record Number: \_\_\_\_\_  
 Pick up Copies       Fax Copies # \_\_\_\_\_  
 Mail Copies       View Record  
ID Confirmed by: \_\_\_\_\_

## **AUTHORIZATION OF DISCLOSURE OF HEALTH INFORMATION**

I hereby authorize St. Josephs Regional Medical Center to disclose health information as specified:

To: \_\_\_\_\_  
*Name of Organization / Person to receive the health information*

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\_\_\_\_\_ *Street Address* \_\_\_\_\_ *Phone Number*

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\_\_\_\_\_ *City* \_\_\_\_\_ *State* \_\_\_\_\_ *Zip Code*

Purpose or need for data: \_\_\_\_\_

Information to be disclosed: \_\_\_\_\_ Date(s) of Hospitalization/Care: \_\_\_\_\_

<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> Pathology
<input type="checkbox"/> History & Physical Exam	<input type="checkbox"/> Radiology Reports
<input type="checkbox"/> Consultation Reports	<input type="checkbox"/> Radiology Films
<input type="checkbox"/> Operative Reports	<input type="checkbox"/> Psych Evaluation
<input type="checkbox"/> Lab	<input type="checkbox"/> Entire Record
<input type="checkbox"/> Other: Specify _____	

I understand that the disclosure may include information relating to (check if applicable):

- AIDS or HIV
- Psychiatric or Mental Health Information
- Drug / Alcohol Abuse Information

I understand that the information to be released may include material that is protected by Federal Law (45 CFR Part 164) and that the information may be subject to redisclosure by the recipient and no longer be protected by the federal regulations. I understand that this authorization may be revoked in writing at any time by notifying the privacy officer, except that revoking the authorization won't apply to information already released in response to this authorization. I understand that SJRMC will not condition treatment, payment, enrollment, or eligibility for benefits on my signing authorization. Unless otherwise revoked, this authorization will expire in 90 days from the date below or in the event of the following condition: \_\_\_\_\_

St. Joseph Regional Medical Center, its employees, officers, copy service contractor, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized by me on this form and as outlined in our Notice of Privacy Practices. My signature below authorizes release of all information specified in this authorization. Any questions that I have regarding disclosure may be directed to the privacy officer at (208) 799-5304 or (208) 799-5276.

St. Joseph Regional Medical Center complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.  
Spanish: St. Joseph Regional Medical Center cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad o sexo.  
German: St. Joseph Regional Medical Center erfüllt geltenden bundesstaatliche Menschenrechtsgesetze und lehnt jegliche Diskriminierung aufgrund von Rasse, Hautfarbe, Herkunft, Alter, Behinderung oder Geschlecht ab.

\_\_\_\_\_  
Signature of Patient \_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Legal Representative & Relationship to Patient/Authority to Act \_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Witness \_\_\_\_\_  
Title \_\_\_\_\_  
Date