ST. JOHN'S EPISCOPAL HOSPITAL, SOUTH SHORE

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION
(Note: This form cannot be used to authorize a release of HIV-related information.)

Individual's Name: _____
Last First Middle

Home Address: _____
_____

Home Telephone: _____ **Date of Birth:** _____

SPECIFY INFORMATION TO BE DISCLOSED: _____
_____
_____

RECIPIENT: Name of person /agency to whom St. John's Episcopal Hospital (the "Hospital") may disclose my health information: _____
Address of the recipient or where my health information should be delivered: _____
_____

TERM: This Authorization will remain in effect:
☐ From the date of this Authorization until the _____ day of _____, 200___.
☐ Until the following event occurs: _____.
☐ Other: _____.

PURPOSE: I authorize the Hospital 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): ____
_____
_____

I understand that once the Hospital discloses my health information to the recipient, the Hospital cannot guarantee that the recipient will not redisclose my health information to a third party as they may not be required by this Authorization or applicable federal and state law governing the use and 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 the Hospital; except, however, if my treatment at the Hospital is for the sole purpose of creating health information for disclosure to the recipient identified in this Authorization, in which case the Hospital 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 the office listed below. The revocation will be effective immediately upon the Hospital's receipt of my written notice, except that the revocation will not have any effect on any action taken by the Hospital in reliance on this Authorization before it received my written notice of revocation.

I may contact the Hospital's Risk Management/Corporate Compliance Office by mail at St. John's Episcopal Hospital, South Shore or by telephone at (718) 869-7665.

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 below, I hereby, knowingly and voluntarily, authorize the Hospital to use or disclose my health information in the manner described above.

_____ _____ _____
Signature of Patient/Personal Representative Relationship to Patient Date