St. Vincent Family Center
REQUEST/RELEASE OF INFORMATION

Name of client:

Other possible names:

Date of birth: Phone #:

Email address:

Address:

City: State: Zip:

I hereby authorize St. Vincent Family Center to disclose or obtain my protected health information as indicated below to or from:

Information may be: ☐ Mailed ☐ Faxed ☐ Emailed ☐ Discussed

Information to be disclosed

From and to Dates:

☐Diagnostic Assessment ☐ Discharge Summary ☐ School/Academic Information

☐ Treatment Progress ☐ ISP ☐ IEP/ETR ☐ Demographic Information ☐ Other

☐ Medication Reconciliation

I understand that this protected health information may include HIV-related information and/or information and/or information relating to diagnosis or treatment of mental illness and/or substance abuse and that by signing this form, I am specifically authorizing the release of information relating to:

☐ Mental Health Treatment

☐ Substance Abuse (including alcohol/drug abuse)

☐ HIV related information (including AIDS related testing)

Purpose for the disclosure:

☐ Changing Provider ☐ Second opinion ☐ Continuing care ☐ Legal

☐ Personal use ☐ Insurance ☐ Workers' Compensation

☐ School ☐ Payment ☐ Other

1. I understand that this authorization will expire one year from the date of my signature

below per the standards set forth by the Council On Accreditation.

2. I understand that I may shorten, extend or revoke this authorization at any time by notifying St. Vincent Family Center in writing at: Privacy Officer, 1490 East Main Street Columbus, OH 43205. This authorization will be shortened, extended or will cease to be effective on the date the written instructions are received. If I revoke or cancel this authorization, it is not effective for the use or for the disclosure of my information that has already occurred.

3. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by state or federal privacy regulations.

4. I understand that my receipt of treatment, the payment for my treatment, and my enrollment or eligibility for benefits or services is not conditioned on signing this authorization unless the authorization is necessary for determining eligibility for the program or enrollment in the program.

5. I have a right to inspect or copy the information that will be used or disclosed because of this authorization.

A photocopy of this form will be considered as valid as the original.

Client name: ______________________________

Signature: ______________________________

Personal representative name, if client is a minor: ______________________________

Personal representative signature: ______________________________

Date: ______________________________

Provider Name: ______________________________

Completed forms must be submitted to the Medical Records Department by any of the following means:

Fax: (614) 358-6408
Email: _medicalrecords@svfc.org
Mail: Medical Records Department, 1490 E. Main St., Columbus, OH 43205