Saint Francis Healthcare
Memphis • Bartlett

AUTHORIZATION FOR RELEASE OF INFORMATION

5959 Park Avenue
Memphis, TN 38119
(901)765-1980 phone
(901) 765-3269 or 765-3133fax

2986 Kate Bond Road
Bartlett, TN 38133
(901) 820- 7630 phone
(901) 820-7631 fax

I, _____, do hereby authorize Saint Francis Healthcare

Or _____to release to_____
Facility / Health Care Provider if other than SFH ***Agency or individual***

Medical information relating to my treatment in said facility for the following purpose only:

The information released shall be limited to the following time period (s) or illness:

Include also the following specific type data (check all that apply):

o Discharge Data	o X-ray	o Lab
o History & Physical	o ER record	o All information in medical record
o Operative Report	o EKG	o Other:_____

Expiration Date: The expiration date of this authorization is_____. If no expiration date or period is documented, it will expire **six (6) months** after the date recorded below.
This authorization covers only treatment prior to the date recorded below.
I understand that I may revoke this authorization at any time with a written request to the Health Information Management Department of Saint Francis Healthcare. The request to revoke this authorization must contain the signature of the patient or the patient's legal representative.
Revocation of this authorization is allowable only to the extent that the release of information has not already occurred and/or only if the facility has not taken action in reliance thereon.
I understand that treatment, payment, enrollment or eligibility for benefits may not be conditioned on obtaining this authorization.
I further understand that any disclosure of records concerning diagnosis and/or treatment for alcohol or drug abuse is covered by Title 42 of the Code of Federal Regulations, and if there is any such information contain within, I hereby authorize the release of this information.
This authorization also includes any information related to diagnosis and/or treatment of any psychiatric or mental illness or any state of infection with the HIV (AIDS) virus or any other sexually transmitted diseases.

Saint Francis Healthcare is hereby released form all legal liability that may arise from the release of the information requested. Please note that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected under applicable federal law.
For questions, please contact Saint Francis Healthcare Privacy Office by phone (901-820-7600, 901-765-2000) or at the above mentioned address or via email at Chris.Hansen@tenethealth.com

_____ _____
Signature of Patient or authorized Individual Date

_____ _____
Relationship if signed by someone other than patient Patient Social Security Number

_____ _____
Street Address Phone Number

_____ _____
City, State, Zip Code Date of Birth

Photo ID provided _____yes _____no If no, the form of ID provided_____