HSHS St. Elizabeth's Hospital

PATIENT AUTHORIZATION FOR RELEASE/REQUEST FOR COMPARISON FILMS

St. Elizabeth's Hospital, Women's Imaging Center, Authorization to Obtain Information

Patient's Name: _____
Former Names (if applicable): _____
Birthdate: _____
Patient Contact #: _____

I HEREBY AUTHORIZE: (please provide as much information as possible)
Prior facility name, address, ph#, fax# _____

_____

_____

to furnish the following radiologic films and reports to:

ST ELIZABETH'S HOSPITAL, DEPARTMENT OF RADIOLOGY
ONE ST ELIZABETH'S BOULEVARD
O'FALLON, IL 62269
Phone: 618−234−2120, Fax: 618−222−4626

*****PLEASE SEND CD'S. If requesting prior mammography studies please include up to 5 years previous along with any prior breast ultrasound or breast M.R.I.*****

I understand that this authorization is for the use and disclosure of radiological information. The result of such disclosure may further disclose the provision of mental health, developmental disability, sexually transmitted disease, alcohol and/or drug abuse services, and HIV/AIDS test results, including but not limited to examination, diagnosis, evaluation, treatment or rehabilitation.

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Health Information Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. If I fail to specify an expiration date, event or condition, this authorization will expire in 90 days.

I understand that the information that is being disclosed under this authorization may be subject to redisclosure by the recipient and no longer be protected under the Health Insurance Portability and Accountability Act.

I agree that a photocopy of this authorization is as valid as the original.

☐ **Do you prefer your images to be permanently transferred and maintained at our facility?**

Date and Type of exams:

_____

_____

☐ Radiographs and Reports
☐ Reports Only

These records are needed for:

☐ Continuation of Care ☐ Legal use

_____
Patient's or Authorized Representative's Signature

_____
Relationship: If signed by other than patient

_____
Witness Signature

_____
Date