St. Joseph's | Candler
www.sjchs.org

AUTHORIZATION FOR RELEASE/RECEIVE INFORMATION

HEALTH INFORMATION MANAGEMENT DEPARTMENT

ST. JOSEPH'S HOSPITAL, Inc.
11705 Mercy Boulevard
Savannah, GA 31419
PHONE: 912.819.2477
FAX: 912.819.2136

CANDLER HOSPITAL, Inc.
5353 Reynolds Street
Savannah, GA 31405
PHONE: 912.819.6767
FAX: 912.819.6664

I hereby authorize St. Joseph's/Candler Health System to release the following information from the health records of:

Patient Name: ______________________ SSN: ______________ DOB: ____________

Address: ______________________ City: ______________________ State: ____________

Zip: ______________ Telephone Number: ______________________

To be released/received to:

Name: ______________________________________ Phone #: ______________

Address: ____

City: ______________________ State: ______________ Zip: ______________

Method of Release: ☐ Mail ☐ Pick Up ☐ Fax ☐ E-delivery via secure internet portal

Email Address

Reason For Request: ☐ Insurance ☐ Legal

☐ Physician (Name/phone/address) ☐ Disability

☐ Personal ☐ Other: ______________________

☐ Other Hospital (Name, Phone, Location): ______________________

Information to be released: (Check all that apply)

☐ Abstract	☐ Emergency Room Record	☐ Radiology Reports	☐ Therapy Notes/Reports
☐ Demographics	☐ Cardiac Cath Report, Echo, EKGs	☐ Radiology Images	☐ Pathology Slides
☐ Dictated Reports (H&P, OP Note, Discharge Summary, Consults)	☐ Laboratory Reports	☐ Medication Administration Record	

☐ Other: ____

For dates of services rendered: ______________________ through: ______________________

I understand that I can revoke this authorization by providing written notice to the Health Information Department of the Hospital at the address listed above or in a manner described in the Notice of Privacy Rights. I also understand that if information has been released by relying upon this Authorization, that revocation will not be valid.

I PLACE NO LIMITATIONS ON HISTORY OF ILLNESS OR DIAGNOSTIC AND THERAPEUTIC INFORMATION, INCLUDING ANY TREATMENT FOR ALCOHOL, DRUG ABUSE OR DEPENDENCY, PSYCHIATRIC OR PSYCHOLOGICAL ILLNESS, MENTAL ILLNESS OR RETARDATION AND ACQUIRED IMMUNE DEFICIENCY (AIDS) SYNDROME.

The Hospital listed above may not condition treatment, payment, on the signing of this authorization, unless allowed by law.

I understand that I am waiving my rights to privacy by releasing my medical information to the parties listed above and this information may be redisclosed by the receiving party. I hereby authorize the entity listed above to release the said information described above.

I understand that this Release of Information will expire within ninety (90) days from the date listed below.

Patient Signature______________________________________ Date______________

Patient's Guardian or Capacity__________________________ Date______________

Relationship to Patient____

For Health Information Management Department Use Only:

Request taken by:______________________________________ Date Completed:______________