St. Thomas East End Medical Center Corporation
4605 Tutu Park Mall, Suite 207
P.O. Box 503177
St. Thomas, VI 00805-3177

OFFICIAL USE
PT# ____________________
INFO: __________________
____
____
I:________RD: ____________

Tel: (340)775-3700
Fax: (340)777-7927

"Your Health is our First Priority"

Patient Disclosure Authorization Form

Patient Name: ____ Date of Birth: ________________________
(Print)

Phone #:______________________________ Email: ____

I authorized disclosure of my protected health information only in the specific manner, for the named, reason, and to the specific individual(s) described below.

Information to be used or disclosed:

- ☐ Alcohol/ Drug Abuse/Treatment *
- ☐ Behavioral Health Records
- ☐ Consult/ Referral
- ☐ Dental Radiograph
- ☐ Dental Records
- ☐ Discharge Summary
- ☐ Entire Medical Record
- ☐ ER Visit
- ☐ HIV/ AIDS related treatment
- ☐ Immunization
- ☐ Operative Report
- ☐ Path/Labs
- ☐ Prenatal Record
- ☐ Procedure
- ☐ Progress Note
- ☐ Radiology
- ☐ Sexually Transmitted Disease (STD)
- ☐ SSA Letter
- ☐ Other: ______________

*42 CFR 2 Part 2 regulations limit the availability of substance abuse records to ensure that individuals in a treatment program are not more vulnerable with respect to their privacy than those who do not seek treatment. Covered information may not only be disclosed or used as permitted by these regulations and may not otherwise be disclosed or used in any civil, criminal, administrative, or legislative proceeding conducted by any federal, state, or local authority.

For the date(s) of service from: ________________________________ to _________________________________

Reason for requested use of disclosure (Check One):

- ☐ Patient Request (Personal Reason)
- ☐ Continuity of Care
- ☐ Employment related or to substantiate a disability claim
- ☐ Military
- ☐ Other: ________________________________

Release my health information to (Check One):

- ☐ Medical Facility
- ☐ Provide a copy of my health information to me
- ☐ Other
- ☐ STEEMCC

Name: ______________________________
Address: ____________________________
City: _______________________________
State: _____________ Zip Code:__________
Phone: ______________________________
Fax: ________________________________
Email:_______________________________

Receive my information from (Check One):

- ☐ Medical Facility
- ☐ STEEMCC

Name: ______________________________
Address: ____________________________
City: _______________________________
State: _____________ Zip Code:__________
Phone: ______________________________
Fax: ________________________________
Email:_______________________________

Event (relating to patient or the purpose of disclosure): ____

This authorization will expire in **90 Days**. Processing time is **5 to 10 business days**. If staff needs more time, patient will be contacted.

This authorization provides that:

- I may revoke this authorization at any time, provided that the revocation is in writing to the Privacy Officer at this practice, except if this practice has taken action relying on this consent or if the authorization was obtained as a condition of obtaining insurance coverage.

Attention: Privacy Officer
St. Thomas East End Medical Center Corporation
4605 Tutu Park Mall, Suite 207
P.O. Box 503177
St. Thomas, VI 00805-3177
Email: privacyofficer@steemcc.org

- Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected by HIPAA privacy rules.
- This practice will not condition treatment on my providing authorization for the requested use or disclosure.
- I have the right to access my protected health information to be used or disclosed.
- I will receive a copy of this completed and signed authorization form.

Signature: ____ Date: ________________________

Please print relationship to patient (if signed by a personal representative of patient): ____________________

Created: June 17, 2020
Revised: July 29, 2020

Reviewed by PI Committee: June 18, 2020
Reviewed by STEEMCC Board: June 19, 2020