Gov. Juan F. Luis Hospital & Medical Center

Authorization to Release/ Disclose Protected Health Information

❖ **Instructions**: Complete all applicable sections to have information disclosed **TO Gov. Juan F. Luis Hospital & Medical Center**. Refusal to complete this form will not affect the quality of or access to care, payment, enrollment, or eligibility for benefits.

Patient Name: _____ **DOB:** _____ **Phone:**_____

Address: _____ **City:** _____ **Zip:** _____

RELEASE INFORMATION

A. In addition to any release of information performed by current standards of operation, I request information be released:

FROM: Name/ Facility Name: _____ Attn: _____

Address: _____ City/ State: _____ Zip Code: _____

Phone: _____ Email: _____ Fax: _____

TO: Gov. Juan F. Luis Hospital & Medical Center
Health Information Management Department
Address: 4007 Estate Diamond Ruby
Christiansted, St. Croix, VI 00820

Phone: (340) 778-6311 **Sent by:** ☐ Certified Mail ☐ **Email:** jflhim@jflusvi.org ☐ **Fax:** (340)772-7302

B. I request that the information be released for the following purpose: (**Initial** all that apply)

____ Continuing Care ____ Transfer of Care ____ Financial Aid ____ Disability Benefits ____ Other: _____

MEDICAL RECORD

A. Information to be released/ disclosed: (**Initial** all that apply)

____ Discharge Summary	____ History & Physical	_____ Consultation Reports
____ Laboratory Results	____ Immunizations	_____ Medication Lists
____ Family Studies	____ Pathology Report	_____ Radiology Reports
____ Billing/ Financial Statement	____ Implant Records	_____ Explanted Materials, Devices, Hardware

____ Any additional/ future documents requested by Gov. Juan F. Luis Hospital & Medical Center from the time specified below.

____ Other: _____

B. Time period or date of information to be released: (MM/YY) From: _____ To: _____

C. Specific Treating Provider Name(s): _____ OR ____ All Medical Providers

D. Specific Clinic/ Service(s): _____ OR ____ All Medical Services

ACKNOWLEDGEMENT

****This authorization form does not authorize the release of Substance Use Therapy Records or Psychotherapy Notes****

❖ I understand that the information in my health record may include information relating to or referencing: Genetic counseling; Human Immunodeficiency Virus (HIV) or Acquired Immunodeficiency Syndrome (AIDS) treatment; history of drug or alcohol use and abuse; mental, behavioral health, or psychiatric care; and/or other sensitive information.

❖ I understand that I have the right to request a copy of this form and may revoke this authorization, in writing, by contacting the organization appointed in the 'FROM' section (above), except to the extent that the organization has relied on the authorization.

❖ I understand that information may be subject to redisclosure by the recipient and no longer protected by the Health Insurance Portability and Accountability Act (HIPAA).

❖ I hereby grant permission to release confidential and/ or protected health information to the entity listed above.

_____ _____ _____

Patient's Name (Print) Patient Signature Date

_____ _____ _____ _____

Legal Representative* (Print) Legal Representative (Sign) Relationship to Patient Date

***Note: Proof of legal authority may be required.** Under HIPAA Privacy Rule 45 (§ CFR 164.510), a spouse, family member, or friend cannot sign a HIPAA release form on behalf of a patient unless criteria for 'Legal Representative' or DPOA is met.

Form meets regulations as outlines in 45 CFR 164.508

01.08.2024 RE/BW