SSMHealth

Request for Access to/Authorization for Use and Disclosure of Protected Health Information

PATIENT NAME:_____
LAST FIRST MI Maiden or Other Name

DATE OF BIRTH:_____-_____-_____ FORMER NAME:_____ MEDICAL RECORD #_____
MO DAY YR

ADDRESS:_____ CITY:_____STATE:____ZIP:_____

DAY PHONE: _____ EVENING PHONE:_____

Type of access requested: ❑ Inspection ❑ Hard Copy ☒ Electronic Copy ***(only available if SSM Health Care maintains the requested information electronically)***

I hereby authorize the following entity (check one) to disclose my protected health information as indicated below:

❑ St. Joseph Hospital- Lake St. Louis ❑ St. Joseph Hospital- St. Charles ❑ St. Joseph Hospital-Wentzville ❑ DePaul Hospital
❑St. Clare Hospital ☒ St. Mary's Hospital ❑Cardinal Glennon Children's Hospital ❑ Other _____

NAME: Dr. Patrick Yeung - Veritas Fertility and Surgery RELATIONSHIP: Physician
ADDRESS: 522 N. New Ballas Rd, Suite 300
CITY: St. Louis STATE: MO ZIP: 63141
PHONE: 314-405-9556 FAX: 314-405-9557

❑ **Mail to the address above** ☒ **Email to the address below** ❑ **Hold for pick up**

E-MAIL ADDRESS:
info@veritasfertility.com

INFORMATION TO BE RELEASED:
DATES: past 12 months

❑ Discharge Summary _____
☒ History & Physical Exam _____
❑ Consultation Reports _____
☒ Progress Notes _____
❑ Lab Reports _____
☒ Imaging Reports _____
❑ Medication Records _____
❑ Emergency Room Records _____
☒ Other (specify content and dates): operative notes from any surgeries with Dr. Patrick Yeung

PURPOSE OF DISCLOSURE:

❑ Changing physicians ❑ Consultation ❑ Insurance/Workers' Compensation ❑ School ❑ Research ❑ At request of individual
❑ Legal (specify): _____
☒ Other (specify): continuation of care
❑ For personal access (specify): ❑ Copy ❑ Inspection ❑ Summary

ACKNOWLEDGEMENT OF UNDERSTANDING:

- I understand the expiration date of this authorization is ❑ _____ ❑ at end of research study; ☒ not applicable for ongoing research.
- I understand that I may revoke this authorization at any time by notifying the providing organization in writing, and it will be effective on the date notified except to the extent action has already been taken in reliance upon it.
- I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by Federal or State privacy regulations.
- By authorizing this use or disclosure of information, there will be no conditions placed on my health care or payment for my health care.
- I understand that if I am being requested to authorize a use or disclosure that, upon request, I will get a copy of this form after I sign it.
- I understand my request will be acted upon within 30 days. If I am not provided access or information cannot be supplied, I understand I will be notified, and have the right to request review of any denial of access other than those made in accordance with applicable law.
- I understand that I may be required to pay the cost of creating paper copies or electronic media, mailing copies, supervising my inspection, or preparing a summary except for uses and disclosures for the purpose of treatment, payment, and operations.
- SSM Health Care believes that the only way to avoid third party interception of information sent through e-mail is to send such information by encrypted e-mail. Despite this warning about the risk that my protected health information could be read/intercepted by a third party if it is not sent by encrypted e-mail, I request SSM Health Care to send an electronic copy (if available) of the requested information by unencrypted e-mail.

I acknowledge and understand the terms of this **Request for Access to/Authorization for Use and Disclosure of Protected Health Information**.

Patient/Legal Representative Signature:_____ DATE:_____

Relationship: _____

Records Released by:_____ DATE:_____ ID VERIFIED:_____