

Saint Francis Hospital
Medical Record & Radiology Film Authorization for Release of Information

Patient Information

Name: _____ Date of birth: _____
Address: _____ Social Security Number: _____
_____ Telephone Number _____

Approximate Dates of Treatment: _____

Type of Treatment Inpatient Outpatient

Treating Facility:
 St. Francis Medical Center St. Francis Central Hospital St. Francis Cranberry

Types of records to be released: Original Medical Records (\$25.00 Fee) Original Radiology Films (\$25.00 Fee)

Purpose of obtaining records: Continuing Medical Treatment Employer
 Insurance Legal
 Study/Research Other _____

Mail To: _____

All records will be mailed via first class certified mail

- I hereby request **IRON MOUNTAIN**, on behalf of **ST. FRANCIS HEALTH SYSTEM**, to release my original medical records and/or radiology films to **MYSELF** at the above address or to the address provided.
- I have been a patient of **ST. FRANCIS HEALTH SYSTEM**, or are the patient's authorized representative. I understand that the facility has legally protected health information about me or the person I represent.
- I fully understand that the contents of my medical records may include but is not limited to information relating to my identity, diagnosis, prognosis and/or treatment, test results, HIV related information, mental health/psychiatric records and/or drug and alcohol treatment and/or abuse. This authorization will expire in six months or: _____.
- I understand that I am not required to sign this authorization for treatment, payment, enrollment or eligibility for benefits on the authorization.

I understand that this authorization is subject to revocation at any time, except to the extent that action has already been taken. A photocopy or facsimile of this authorization will be considered valid unless otherwise specified. I also understand and agree that this authorization will terminate as set forth above unless the request has already been processed. I understand and acknowledge the potential for information disclosed pursuant to this authorization may be subject to re-disclosure and is no longer protected under federal privacy laws.

I HEARBY STATE THAT I HAVE READ AND FULLY UNDERSTAND THE ABOVE STATEMENTS AS THEY APPLY TO ME. I CONSENT TO THE RELEASE OF REORDS FOR THE PURPOSE (S) STATED ABOVE.

Patient or Representative Signature

Date

(If the patient is a minor {age 14 to 18} and received mental health and/or substance abuse treatment, they must sign this release)

Parent or Legal Guardian Signature

Date

If patient is unable to sign please state reason:

(Legal Representative signature will require attaching supporting legal documentation to include; Death Certificate, Power of Attorney, Executor of Estate papers to support your claim as to being the legal representative.)

General Information:

Iron Mountain has medical records from approximately 1996 until the time of closure in 2002. We have Pediatric files from approximately 1980 until the time of closure in 2002.

Radiology films are only available from 1997 to 2000. In 2000 Saint Francis went to an electronic system. Iron Mountain was only given a copy of the reports to cover that time period and therefore will be no films to send from 2000 to 2002. These electronic records did not include mammograms, bone scans and cardiology x-rays. Mammograms, bone scans and cardiology films can be sent for this time period.

There is a processing fee for medical record and radiology film request.

Medical Record

Radiology Film

Total Fee \$25.00

Total Fee \$25.00

Mail completed request and payment to:

Iron Mountain
1739 East Carson Street, #362
Pittsburgh, PA 15203
412-481-4134

ALL REQUESTS MUST BE RECEIVED NO LATER THAN 10/12/2007