HIPAA AUTHORIZATION FOR ADULT OR CHILD AGE 0 TO 13
FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION:

PURPOSE OF THE DISCLOSURE: To allow an individual designated as a Proxy to view health information about the patient through *myCSVFolder.*

I authorize CHRISTUS ST. VINCENT Regional Medical Center (CSVRMC) to release health information via *myCSVFolder* Patient Portal to the designated Proxy.

The following information will be released: Any and all information as available through myCSVFolder.

- I understand that I have a right to revoke this authorization at any time in writing. The revocation should be addressed to CSVRMS Department of Health Information Services.
- I understand that this authorization is in effect until it is revoked by me in writing.
- I understand that any revocation will not apply to information that has already been released in response to this authorization.
- I understand that the health information available in *myCSVFolder* may include Information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV), birth control, pregnancy or family planning, and genetic testing. It may also include Information about behavioral or mental health services, or treatment for alcohol and drug abuse.
- I understand that authorizing the disclosure of this health Information is voluntary. I can refuse to sign this authorization and if I refuse to sign this authorization, I cannot be denied treatment.
- I understand that any information disclosed may be re-disclosed by the recipient and is no longer protected by federal privacy regulations. If I have questions about HIPAA and my rights related to the disclosure of my health information, I may contact the CSVRMC Privacy Officer at (505) 913-532.
- I agree to waive and release my physician, CSVRMC and affiliated entitles, and its officers, directors, employees, agents, successors, and assigns from any and all claims or causes of action that are in any way related to use of myCSVFolder by me or my designated Proxy.
- I understand that the health information available online through myCSVFolder is **NOT** an official copy of my medical record and does **NOT** contain all of my health information. If I need an official copy of my medical record for any purpose, I understand that there may be search, handling and photocopying fees associated with obtaining an official copy of medical records. I understand that I must contact CSVRMC Health Information Services at (505) 913-5320. I also understand that there may be search, handling, and photocopying fees associated with obtaining an official copy of medical records.

I have read (or had read to me) this document and have had all of my questions answered.

Signature of Person Authorizing:_____ Date:_____

[ ] Patient [ ] Legal Guardian [ ] Healthcare Power of Attorney

***Notice to recipients of Alcohol & Drug Abuse Information: The confidentiality of alcohol and drug abuse patient records maintained by CSVRMC and disclosed to you pursuant to this authorization, is protected by Federal lav1 and regulations (see 42 U.S.C. §290dd-3 and 290ee-3, and 42 C.F.R. pt 2). Generally, you may not further disclose the Identity of the patient, or any information Identifying the patient as an alcohol or drug abuser, unless: (a) the patient consents In writing; (b) the disclosure Is allowed by a court order; or (c) the disclosure Is made to medical personnel In an emergency car e situation or to qualified personnel for research, audit, or program evaluation purposes. Violation of Federal la\'IS or regulations Is a crim e. Suspected violations should be promptly reported to appropriate authorities, In accordance with Federal regulations. Federal laws and regulations do not protect any information about a crime committed by a patient or about any threat to commit a crime. Federal laws and regulations also do not protect information about suspected child abuse or neglect from being reported under State Jaw or regulations to the appropriate State or local authorities.**

PATIENT INFORMATION (LABEL)

Name _____
Date of Birth _____ Date of Service _____
Medical Record No. _____
Account No. _____