St John's

BRICKSTONE | FOUNDATION | HOME | MEADOWS

Medical Records Request

Medical Records will only be released with written consent of the applicant or responsible party. Attached is the Authorization to Use and Disclose Protected Health Information document used to provide necessary consent.

Please begin by completing the name, last four digits of the applicant's social security number, and date of birth.

Next, please complete the box located on the upper right side of the document. Be sure to include the name, address, telephone number, and fax number of the primary care physician of the applicant.

Lastly, please sign and return this document to the Welcome Center. The document may be returned by fax to 585-271-1006 or mailed to:

Attn: The Welcome Center
St. John's Home
150 Highland Avenue
Rochester, NY 14620

Upon receipt of the completed consent form, a Welcome Center staff member will fax it to the primary care physician's office that has been designated.

Feel free to contact our office at 585-760-1395 with questions or concerns regarding this request.

Sincerely,
The Welcome Center Team

St. John's Health Care Corporation
St. John's Penfield Homes Corporation
150 Highland Ave. Rochester, NY 14620

Authorization to Use and Disclose Protected Health Information

Name: _____ SS # XXX-XX-_____ DOB_____/_____/_____

[ ] I authorize St. John's to release information to:	[ ] I authorize St. John's to obtain information from:
_____ Name of Provider or Facility	_____ Name of Provider or Facility
_____ Address	_____ Address
_____ City, State, Zip Code	_____ City, State, Zip Code
_____ Phone # Fax #	_____ Phone # Fax #

The Protected Health Information that may be used or disclosed is: (Check all that apply)

[ ] All records	[X] Progress Notes	[X] Discharge Summary
[X] History & Physical	[X] Immunization Records	[X] Lab Work/X-Rays
[ ] MDS	[ ] Nursing Assessments	[ ] Care Plan
[X] Medication Records	[ ] Therapy Records	[X] Last 3 Office Visit Reports

Send to the Attention of: St. John's Welcome Center/Admissions (Fax # 585-271-1006)

I understand that this will include information relating to: (check if applicable)
[ ] Behavioral Health Services/Psychiatric Care [ ] Treatment for Drug and or Alcohol Abuse

Dates: **From One Year Prior** To: **Present Date**
The purpose of this Use or Disclosure of Protected Health Information is for review for admission and medical care provided during residency at St. John's Home or St. John's Penfield Homes.

I have read and understand the terms of this authorization (printed on reverse side). I have had an opportunity to ask questions about the use and disclosure of my Protected Health Information.

Signature of Client or Designated Representative_____

Print Name of Client or Designated Representative_____

Description of Designated Representative's Authority: HCP ____Other_____ Date:_____

Expiration: This authorization expires on_____
(insert applicable date or event)

Cancellation of Authorization: I wish to revoke this authorization effective as of the date noted below:

Signature:_____ Date:_____

Rev. 11-30-2018