Saint Agnes Medical Center
A Member of Trinity Health

AFFIX PATIENT LABEL OR WRITE
Patient's Name: _____
Date of Birth: _____
Today's Date: _____

Authorization for Release of Confidential Information (English)

Patient's Name: _____ Patient's Birthdate: _____

Patient's Address: _____

City, State, Zip: _____Phone: (____) _____

Description of Medical Records Requested:
Date(s) of Service (required): _____
(Check boxes below)

- ☐ All Medical Information
- ☐ Abortion and abortion-related services
- ☐ Behavioral/Mental Health
- ☐ Billing Documents
- ☐ Cardiology Images
- ☐ Cardiology Reports
- ☐ Consultation
- ☐ Contraceptive Services
- ☐ Discharge Summary
- ☐ EKG
- ☐ Emergency Room Visit
- ☐ Gender-affirming care
- ☐ HIV/AIDS Test Result
- ☐ Lab/Pathology Results
- ☐ Medication Record
- ☐ Operative/Procedure Note
- ☐ Radiological Images
- ☐ Radiological Reports
- ☐ Other: _____

Intended use of Information:
☐ Patient/Personal Use ☐ Continuing Care ☐ Third Party

I direct the medical records indicated above to be provided to the following:
Name: _____ Phone (____) _____
Address: _____
Street City State Zip

Delivery Method (check one box):

- ☐ MyChart
- ☐ Email Secure: _____
- ☐ Email Unsecure: _____
  *Unencrypted e-mail has some level of risk that your medical information could be read or otherwise accessed by a third party while in transit. By checking this box and signing you accept this risk and still want your medical information sent by unsecured email.
- ☐ Mail - CD
- ☐ Mail - Paper
- ☐ Fax: _____

Signature Required on Reverse Side/Second Page

1. You may revoke this authorization at any time, but only in writing mailed to: Saint Agnes Medical Center c/o Health Information Management 1303 E. Herndon Ave. Fresno, CA 93720. Your Revocation will be effective upon receipt; only to the extent that Saint Agnes Medical Center has not already relied on this authorization.
2. You may receive a copy of this authorization.
3. You may refuse to sign this authorization, and your refusal will not affect your ability to obtain treatment or payment or eligibility for benefits.
4. Medical information released under this authorization may be subject to redisclosure by the recipient, and it may not be protected under state or federal information privacy laws.
5. This authorization will automatically expire 6 months after the date of signature below, excluding Patient Portal enrollment.
6. This authorization is not valid unless all required elements are completed.

I authorize Saint Agnes to release medical information as stated in this authorization:

Signature of Patient or Personal Representative	Date (Must be dated)
Printed Name of Patient Representative (If not signed by the patient)	Authority to Act as Representative (Documentation required)

Return completed form to: Email: frhsmedicalrecords@samc.com

or Health Information Management 1303 E. Herndon Ave. Fresno, CA 93720

Office Use Only

☐ ID Verified Released: _____ Department: _____ Date: _____