Form 4556A
St. Jude Children's Research Hospital
262 Danny Thomas Place
Memphis, TN 38105-3678
Rev. 11/20

_____
Patient Name (please print)

Patient Medical Record Number: _____

AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION TO ST. JUDE CHILDREN'S RESEARCH HOSPITAL

1. I hereby authorize (give permission for): _____
(*name of hospital, clinic, or doctor*)
to disclose the health information specified below from the medical record of the patient named above.
2. Information to be used or disclosed: (check the correct boxes and fill in the blanks where needed)

❑ Discharge Summary	❑ X-Ray Report	❑ EKG/Echo Report	Psychology:
❑ History and Physical	❑ Operative Report	❑ Pathology Report	❑ All notes
❑ Progress and Doctor Notes	❑ Laboratory Report	❑ Consult Report	❑ Summary of notes
❑ Entire Record	❑ other (please describe): _____		❑ Psychological Testing Reports
❑ Itemized Billing	_____		

Records for the period (date) from _____ to _____

3. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.
4. Information is to be disclosed to: St. Jude Children's Research Hospital
Attn: HIMS, Mail Stop 104
262 Danny Thomas Place
Memphis, TN 38105-3678
5. Purpose of disclosure: _____
6. I understand that I have a right to revoke (take back) this authorization (permission) at any time. I understand that if I revoke this authorization, I must do so in writing and provide my written revocation to the Health Information Man-agement Services department. I understand that the revocation will not apply to information that has already been re-leased in response to this Authorization.
7. If not revoked before such time, this authorization will expire one (1) year from the date below unless otherwise noted.
8. I understand that after the above information is disclosed, it may be redisclosed (given out again) by St. Jude to other entities and the information may not be protected by federal privacy laws or regulations.
9. I understand that authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure health care treatment.

_____	_____	_____
Signature of patient or parent/legal guardian if patient is younger than 18	Date	Time (AM/PM)

If signature not patient's, relation to patient: _____

_____	_____	_____
Witness signature:	Date	Time (AM/PM)

Form 4556A
St. Jude Children's Research Hospital
262 Danny Thomas Place
Memphis, TN 38105-3678
Rev. 11/20

_____
Patient Name (please print)

Patient Medical Record Number: _____

AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION TO ST. JUDE CHILDREN'S RESEARCH HOSPITAL

1. I hereby authorize (give permission for): _____
(*name of hospital, clinic, or doctor*)
to disclose the health information specified below from the medical record of the patient named above.
2. Information to be used or disclosed: (check the correct boxes and fill in the blanks where needed)

❑ Discharge Summary	❑ X-Ray Report	❑ EKG/Echo Report	Psychology:
❑ History and Physical	❑ Operative Report	❑ Pathology Report	❑ All notes
❑ Progress and Doctor Notes	❑ Laboratory Report	❑ Consult Report	❑ Summary of notes
❑ Entire Record	❑ other (please describe): _____		❑ Psychological Testing Reports
❑ Itemized Billing	_____		

Records for the period (date) from _____ to _____

3. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.
4. Information is to be disclosed to: St. Jude Children's Research Hospital
Attn: HIMS, Mail Stop 104
262 Danny Thomas Place
Memphis, TN 38105-3678
5. Purpose of disclosure: _____
6. I understand that I have a right to revoke (take back) this authorization (permission) at any time. I understand that if I revoke this authorization, I must do so in writing and provide my written revocation to the Health Information Man-agement Services department. I understand that the revocation will not apply to information that has already been re-leased in response to this Authorization.
7. If not revoked before such time, this authorization will expire one (1) year from the date below unless otherwise noted.
8. I understand that after the above information is disclosed, it may be redisclosed (given out again) by St. Jude to other entities and the information may not be protected by federal privacy laws or regulations.
9. I understand that authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure health care treatment.

_____	_____	_____
Signature of patient or parent/legal guardian if patient is younger than 18	Date	Time (AM/PM)

If signature not patient's, relation to patient: _____

_____	_____	_____
Witness signature:	Date	Time (AM/PM)

DEPARTMENT

Form 4556A
St. Jude Children's Research Hospital
262 Danny Thomas Place
Memphis, TN 38105-3678
Rev. 11/20

_____
Patient Name (please print)

Patient Medical Record Number: _____

AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION TO ST. JUDE CHILDREN'S RESEARCH HOSPITAL

1. I hereby authorize (give permission for): _____
(*name of hospital, clinic, or doctor*)
to disclose the health information specified below from the medical record of the patient named above.
2. Information to be used or disclosed: (check the correct boxes and fill in the blanks where needed)

❑ Discharge Summary	❑ X-Ray Report	❑ EKG/Echo Report	**Psychology:**
❑ History and Physical	❑ Operative Report	❑ Pathology Report	❑ All notes
❑ Progress and Doctor Notes	❑ Laboratory Report	❑ Consult Report	❑ Summary of notes
❑ Entire Record	❑ other (please describe): _____		❑ Psychological Testing Reports
❑ Itemized Billing	_____		

Records for the period (date) from _____ to _____

3. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.
4. Information is to be disclosed to: St. Jude Children's Research Hospital
Attn: HIMS, Mail Stop 104
262 Danny Thomas Place
Memphis, TN 38105-3678
5. Purpose of disclosure: _____
6. I understand that I have a right to revoke (take back) this authorization (permission) at any time. I understand that if I revoke this authorization, I must do so in writing and provide my written revocation to the Health Information Man-agement Services department. I understand that the revocation will not apply to information that has already been re-leased in response to this Authorization.
7. If not revoked before such time, this authorization will expire one (1) year from the date below unless otherwise noted.
8. I understand that after the above information is disclosed, it may be redisclosed (given out again) by St. Jude to other entities and the information may not be protected by federal privacy laws or regulations.
9. I understand that authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure health care treatment.

_____	_____	_____
Signature of patient or parent/legal guardian if patient is younger than 18	Date	Time (AM/PM)

If signature not patient's, relation to patient: _____

_____	_____	_____
Witness signature:	Date	Time (AM/PM)