APPLICATION FOR HOLY ORDERS: DEACON
FORM 4: HIPPA COMPLIANT AUTHORIZATION FOR RELEASE OF RECORDS – MEDICAL / PSYCHOLOGICAL / PSYCHIATRIC

DIRECTIONS: You may print this form and complete it manually OR you may type your responses on this form then print it for further processing.

PRINT full name:		
Date (m/d/y) of birth:	SSN:	Health Record #:
Current street address:		
City:	State:	ZIP code:

I authorize the verification of the information provided on this form as to my credit and employment. I have received a copy of this application.

1. The following named individual or organization is authorized to make the disclosure:

_____

2. The type and amount of information to be used or disclosed is as follows:

- *The complete report of my medical records.*
- *The complete report of my psychological examination.*
- *The complete report of my psychological evaluation.*

3. This information may be disclosed to and used by The Episcopal Diocese of Rhode Island, 275 North Main Street, Providence, RI 02903, for the purpose of processing the patient's application for Holy Orders and retained in the permanent file of the Diocese.

4. 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.

5. I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

Unless otherwise revoked, this authorization will expire three years from the date below.

6. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand I may inspect or copy the information to be used or disclosed, as provided in 45 CFR 164.524. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

7. The physician-patient or other privilege is not waived. You are specifically requested and instructed not to disclose any information, opinions, records or x-rays to any other attorney, physician, insurance company or person without specific additional written authorization from me to do so, unless said disclosure is necessary for health care or health insurance purpose. ARS § 12-2235. All other authorizations are hereby revoked and canceled.

8. Photocopies of this authorization will be considered as valid as the original.

Signature of applicant:	Date (m/d/y):

NOTE: On or before October 15, please complete this form, keep one copy for yourself, make two additional copies, one for your medical doctor and one for the psychiatrist/psychologist, and then mail this completed form to:

Bishop's Office, Episcopal Diocese of Rhode Island, 275 North Main Street, Providence, Rhode Island 02903-1298