ROSARY HALL

Dear Dr. _____ : Date sent to PCP _____

Your patient was recently evaluated at our program. We hope the following information will be helpful in coordinating the patient's care.

Patient Name:	Patient's date of birth:
Date of Initial Consultation:	Date of Next Appointment:
Diagnoses/Presenting Problem(s):	
Interventions and Goals:	
Follow-up Care:	
Medications:	

Please call Rosary Hall clinical staff at 216-363-2580 or number below for further information.
Sincerely,

_____ _____

Clinician Signature Telephone

Authorization for the release of Medical Information

This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal Regulation (42CFR, Part 2) prohibits you from making any further disclosures of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute the patient.
I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance on it. This authorization will automatically expire three months from the date signed.

I, _____ hereby authorize St. Vincent Charity Hospital and its employees to release information to my primacy care physician _____ .

This release is for the purpose of continuity of care. The information to be released is:

(please check One)

- ☐ Any applicable information from my entire record
- ☐ Only the information listed above
- ☐ No information is to be released to my primary care physician listed above

_____ _____

Date Signed Signature of Patient or Representative

_____ _____

Witness Signature and Relationship of Signer. If not Patient

ST. VINCENT CHARITY
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CLEVELAND, OH 44115
stvincentcharity.com
A Ministry of the Sisters of Charity Health System

PATIENT LABEL