FLORIDA HOSPITAL

The skill to heal. The spirit to care.

Medical Record Number: _____
(for internal purposes)

AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION
MEDICAL RECORDS DEPARTMENT

Patient Name: _____ Social Security Number: _____

Previous Name, if applicable:_____Date of Birth: _____

Address: _____ City: _____ State: _____

Zip Code: _____ Home Phone: _____ Work Phone: _____

1. FLORIDA HOSPITAL

I authorize representatives from the following facility/facilities to disclose the health information as directed below:

Check only one: ***(separate request form required for records from each facility desired)***

- ☐ Florida Hospital SouthEast Memorial
- ☐ Florida Hospital NorthEast
- ☐ Florida Hospital Childrens Care
- ☐ Florida Hospital Medical Center
- ☐ Florida Hospital Regional
- ☐ Florida Hospital South
- ☐ Florida Hospital Central University
- ☐ Florida Hospital Langevelt

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2. RECEIVING PARTY

Please send my health information to:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

*Fax Number: * for medical purposes only (emergent or in office) _____

3. DESCRIPTION OF HEALTH INFORMATION TO BE DISCLOSED:

- ☐ Complete medical record (***Please specify dates of service***)_____
  - OR -
- ☐ Partial medical record (***Please check specific sections needed below)***

☐ *You must check this box if you are also requesting Billing Records*

Information	Dates	Information	Dates
☐ History & physical	_____	☐ Office notes	_____
☐ Consultations	_____	☐ Operative reports	_____
☐ Discharge summary	_____	☐ Pathology reports	_____
☐ Lab results	_____	☐ EKG reports	_____
☐ X-ray Reports	_____		
☐ CD / Films	_____		

☐ Other (*Please specify content and dates of service*):_____

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4. PURPOSE OF DISCLOSURE

☐ At my request

☐ Other: _____

5. EXPIRATION OF AUTHORIZATION

Unless I request in writing otherwise**,** I understand that this authorization will expire on _____ _____ (*Insert expiration date or event*). If I do not specify an expiration date or event, this authorization will expire ninety (90) days from the date on which I signed this authorization.

6. RIGHT TO REVOKE AUTHORIZATION

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Medical Records Department(s) of the Florida Hospital or facilities checked above. A list of addresses for the Medical Records Departments is contained in the Florida Hospital Notice of Privacy Practices. I understand that the revocation will not apply to any health information that has already been released in response to this authorization.

7. RE-DISCLOSURE

I understand that if my health information is disclosed to a party other than a health care provider, health plan or health care clearinghouse subject to the federal privacy regulations, my health information disclosed pursuant to this authorization may no longer be protected by the federal privacy regulations.

8. FEES

I understand that federal and state laws allow a fee to be charged for the copying of patient records and I will be responsible for the payment of such fees.

9. REFUSAL TO AUTHORIZE USE AND/OR DISCLOSURE

If I have been asked to sign this form in order to authorize the disclosure of my health information for purposes related to research, or for other reasons, I understand that Florida Hospital may decline to treat me if I refuse to sign this authorization only if: (1) the treatment would be related to a research project and this authorization is for the use or disclosure of my health information for such research; or (2) the treatment would be for the sole purpose of creating health information for disclosure to a third party (such as a workers compensation examination).

10. RELEASE AND WAIVER

If the health information that I have requested Florida Hospital to disclose contains any privileged psychiatric or psychological information related to the treatment of physical and/or mental illness, chemical dependency or alcohol abuse, or testing or treatment of any communicable or infectious disease such as acquired immunodeficiency syndrome (AIDS), Immunodeficiency Syndrome Related Complex (ARC), human immunodeficiency virus (HIV), Venereal Disease, Tuberculosis, or Hepatitis, I hereby waive any privilege concerning such information for the purpose(s) of releasing it to the party or parties authorized above. I also release Florida Hospital each of the Florida Hospital checked above, and their officers, trustees, agents and employees from any and all liabilities, damages and claims, which might arise from the release of the health information authorized by me above.

_____ _____

Signature of Patient (or Patient's Representative) Date

_____

Description of Authority to Act for Patient

NOTE: A COPY OF THIS COMPLETED, SIGNED AND DATED FORM MUST BE PROVIDED TO THE PATIENT AND/OR PATIENT'S REPRESENTATIVE AND A COPY MUST BE PLACED IN THE PATIENT'S MEDICAL RECORD