# Authorization for Use and/or Disclosure Form

FRi - Diagnostic Imaging
Florida Hospital Connected Care

## Authorization for use and/or discloures of protected health informaton (PHI) (Medical Record)

**PLEASE READ THE ENTIRE FORM, ALL 3 PAGES, BEFORE SIGNING BELOW.**

**Individual (name and information of person whose health information is being disclosed):**

Patient Name: (first & last) _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

You may use this form to allow limited access to and use of your health information by certain persons for certain purposes. Your choice on whether to sign this form will not affect your ability to get medical treatment, payment for medical treatment, or health insurance enrollment or eligibility for benefits.

By signing this form, I voluntarily authorize, give my permission and allow use and disclosure (including paper, oral and electronic interchange):

OF WHAT: (Place your initials by one of the following options)

_____ ALL MY HEALTH INFORMATION including information about sensitive conditions (if any). Health information includes, but is not limited to, all records and other information regarding my health history, treatment, hospitalization, tests, and outpatient care, and also educational records that may contain information about my health. This includes my specific permission to release any and all of the following information:

a. Drug, alcohol, or substance abuse

b. Psychological, psychiatric or other mental impairment(s) or developmental disabilities (excludes "psychotherapy notes" as defined in HIPAA at 45 CFR 164.501)

c. Sickle cell anemia

d. Birth control and family planning

e. Records which may indicate the presence of a communicable disease or non-communicable disease; and tests for or records of HIV/AIDS or sexually transmitted diseases or tuberculosis

f. Genetic (inherited) diseases or tests

g. Copies of educational tests or evaluations, including Individualized Educational Programs, assessments, psychological and speech evaluations, immunizations, recorded health information (such as height, weight), and information about injuries or treatment.

_____ ONLY THE INFORMATION INDICATED BELOW (initial next to all that you want disclosed):

_____ Radiology Reports & Images

List Service Date(s): _____

Check All that Apply: _____

☐ Mammogram ☐ X-Ray ☐ MRI ☐ CT ☐ Ultrasound/Sonogram

☐ Special Procedure ☐ Other:

_____ Other

List Service Date(s): _____

PHI Item(s): _____

Release Format: ☐ CD with Image(s) ☐ Print out of Image(s) ☐ Report Only

Delivery Method: ☐ Pickup ☐ Mail (list address) _____

Information created before or after the date of this form may be disclosed, unless you specify a date range of records here:

From Date (mm/dd/yyyy): _____ To Date (mm/dd/yyyy): _____

# Authorization for Use and/or Disclosure Form (continued)

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## FROM WHOM:
Persons/organizations providing the information: (Complete w/Address)

_____

## TO WHOM:
Persons/organizations permitted to receive my information: (Complete w/Address)

_____

## PURPOSE: (check all that apply)

- ☐ My medical treatment and related services and products
- ☐ To evaluate and improve patient safety and the quality of medical care provided to all patients
- ☐ Payment (as defined in HIPAA at 45 CFR 164.501)
- ☐ Eligibility for certain health care services (e.g., hospice) please specify: _____
- ☐ Eligibility for clinical trials, if limited, please specify here: _____
- ☐ Scientific research with proper Institutional Review Board approval or waiver
- ☐ Personal Health Record for my use
- ☐ Personal use Other, please specify: _____

## EFFECTIVE PERIOD: This authorization/permission form will remain in effect until (check one):

- ☐ The day I withdraw my permission or the date of my death
- ☐ A specific date (mm/dd/yyyy): _____
- ☐ A specific event. Please specify: _____

## REVOKING YOUR PERMISSION:
I can revoke my permission at any time by giving written notice to the person or organization to whom I originally gave this form.

## IN ADDITION:

I authorize the use of a copy (including electronic copy) of this form for the disclosure of the information described above.

I understand that there are some circumstances in which this information may be re-disclosed to other parties and no longer protected by federal privacy laws (see page 3 for details).

I understand that refusing to sign this form does not stop disclosure of my health information that is otherwise permitted by law without my specific authorization or permission.

I have read all pages of this form and agree to the disclosures above from the types of sources listed.

X _____ _____
Signature of Patient or Patient's Legal Representative — Date Signed (mm/dd/yyyy)

_____
Print Name of Legal Representative (if applicable)

Check one to describe the relationship of Legal Representative to Patient (if applicable):

☐ Parent of minor ☐ Guardian ☐ Other personal representative (explain): _____

*Note: This form is invalid if modified. You are entitled to get a copy of this form after you sign it.*

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Request Completed By: _____ Completed: (mm/dd/yyyy) _____

- ☐ Faxed: I verified patient's first and last name, DOB, and physician's fax number (initials) X _____
- ☐ Mailed: I verified patient's first and last name, and DOB, and the mailing address (initials) X _____
- ☐ Picked Up: I asked for person's ID, verified patient's disclosure permissions in EHR (initials) X _____

## FURTHER EXPLANATION OF THIS FORM

Laws and regulations require that some sources of personal information have a signed authorization or permission form before releasing it. Also, some laws require specific authorization for the release of information about certain conditions and from educational sources.

**Definitions:** In this form, the term "treatment," "healthcare operations," "psychotherapy notes," and "protected health information" are as defined in HIPAA (45 CFR 164.501).

Note on Mental Health Records: If you are requesting a copy of your mental health records with this form, Florida allows such access, unless such access is determined by your physician to be harmful to you. For more information, see Florida Statute 394.4615(10).

**"To Whom":**

- If you specified a healthcare provider in the "TO WHOM" section above, this permission would also include physicians, other health care providers (such as nurses) and medical staff who are involved in your medical care at that organization's facility or that person's office, and health care providers who are covering or on call for the specified person or organization, and staff members or agents (such as business associates or qualified services organizations) who carry out activities and purpose(s) permitted by this form for that organization or person that you specified.

- If you specified an organization other than a healthcare provider in the "TO WHOM" section above, this permission would also include that organization's staff or agents and subcontractors who carry out activities and purpose(s) permitted by this form for that organization that you specified.

**Revocation:** You have the right to revoke this authorization and withdraw your permission at any time regarding future uses by giving written notice. You should understand that organizations that had your permission to access your health information may copy or include your information in their own records. These organizations, in many circumstances, are not required to return any information that they were provided nor are they required to remove it from their own records.

**Re-disclosure of Information:** Any health information about you may be re-disclosed to others only to the extent permitted by state and federal laws and regulations. You understand that once your information is disclosed, it may be subject to lawful re-disclosure, in accordance with applicable state and federal law, and in some cases, may no longer be protected by federal privacy law.

**Limitations of this Form:** This form does not obligate your health care provider or other person/organization listed in the "From Whom" or "To Whom" section to seek out the information you specified in the "Of What" section from other sources. Also, this form does not change current obligations and rules about who pays for copies of records.