Request for Access and Authorization for Use and/or Disclosure of Protected Health Information

I understand that the protected health information specified below may include mental health, substance abuse (e.g., drugs, alcohol) HIV/AIDS status information, diagnostic and treatment records.

I have read and understand the following statements:

1. I may revoke this authorization at any time by notifying AdventHealth Imaging Centers in writing.
2. I understand that my revocation does not affect any disclosure made prior to the revocation being received and processed.
3. I understand the information disclosed may be subject to re-disclosure and no longer be protected by federal or state privacy laws.
4. I understand that I am signing this form voluntarily and I am signing this under my own free will. AdeventHealth Imaging will not condition my treatment, payment enrollment in health plans or my eligibility for benefits by signing this form.
5. I understand that I will receive a signed copy of this form.
6. I further agree to pay charges to provide the information request per Florida Statute and Administrative Rule.
7. I understand that unless otherwise revoked, this authorization will expire upon the following date, event or condition: ___________.

   If no expiration date, event or condition is noted, this authorization will expire 1 year from the date signed.

☐ I am the patient and I understand and agree to the provisions of this form/authorization.

☐ I understand and agree to the provisions of this form on behalf of the individual indicated below to be the patient. I have signed my name individually as the representative of the patient and have attached a copy of the court order designating me as the guardian of the patient, or documentation designating me as the Legally Authorized Person (LAP) of the patient.

Patient's Legal Name: _________ MRN: ____

Address: ____ Date of Birth: ______________________

Patient Phone Number: ______________________________________ Last 4 of SSN: ______________________

I authorize AdventHealth Imaging Centers to receive from or send to:

Persons/organizations **providing** the information: (Complete with address)

Persons/organizations **receiving** the information: (Complete with address)

I understand that all records will be in paper format and mailed unless specified. ☐ Pick Up at ____________Location ___________☐ Electronic

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The purpose of this request

☐ Personal Request ☐ Treatment(Continued Care) ☐ Other: ______________________________________

Please furnish the following information specified below for the following visit dates:______________________Check appropriate boxes below.

☐ Radiology Reports ☐ Radiology Images ☐ Complete Radiology Records

Patient Signature: ______________________________________Printed Patient Name:______________________

Legally Authorized Person Signature: ___________________________Print Name: ___________________________

Witness Signature:______________________________________Date: ____________________

Request for Access has been: ☐ ☐ ☐ Granted________________________________ ☐ Partially Denied ☐ Denied

Medical Records released/accessed: Date of release/Access ______________________ By:______________________________

Please submit this completed Request for Access and Authorization for Use and/or Disclosure of Protected Health Information to the AdventHealth Imaging Center where you were treated.

You have the right to complain to the Office for Civil Rights. The following is the contact information: Office for Civil Rights - U.S. Department of Health & Human Services | 61 Forsyth Street, SW Suite 3B70 | Atlanta, GA 30323 | 404-562-7886; 404-331-2867 | 404-562-7881 FAX