AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

PATIENT NAME: ________________________________ **PATIENT DATE OF BIRTH:** _______________________

ADDRESS: ____ **CITY:** ______________________**STATE:** _______ **ZIP:** _________

PHONE NUMBER: _____________________________________

RELEASE TO: (ONE PERSON/ORGANIZATION PER FORM)

NAME: _______________________________________ **ADDRESS:** ____

PHONE/FAX NUMBER: __________________________ **CITY, STATE, ZIP:** ____

I REQUEST COPIES OF MY MEDICAL RECORDS:

☐ **FOR MY PERSONAL USE** ☐ **FOR MY PHYSICIAN**

TYPE OF INFORMATION TO BE RELEASED. PLEASE SELECT FROM THE FOLLOWING:

☐ **DISCHARGE SUMMARY** ☐ **RADIOLOGY REPORTS**

☐ **HISTORY AND PHYSICAL** ☐ **LABORATORY REPORTS**

☐ **OPERATIVE REPORTS** ☐ **EKG, ECHO, STRESS, CATH**

☐ **CONSULTATION REPORTS** ☐ **PATHOLOGY**

☐ **EMERGENCY ROOM REPORTS** ☐ **OTHER** _________________________________

SPECIFY THE DATE OR TIME PERIOD FOR INFORMATION SELECTED

FROM: _________________ **TO:** ___________________

**** I UNDERSTAND THAT THE INFORMATION TO BE RELEASED MAY CONTAIN REFERENCE TO ANY DRUG, ALCOHOL, PSYCHIATRIC AND/ OR MENTAL HEALTH CONDITIONS. PLEASE INTIAL: _____________

SIGNATURE: ____ **DATE:** __________ **,20** ___ **.**

NOTICE OF RIGHTS AND OTHER INFROMATION:

THIS AUTHORIZATION WILL EXPIRE AUTOMATICALLY 90 DAYS AFTER THE DATE SIGNED. YOU MAY REVOKE THIS AUTHORIZATION AT ANY TIME BY NOTIFYING FLORIDA HOSPITAL NORTH PINELLAS, IN WRITING OF YOUR INTENT TO REVOKE SEND TO THIS ADDRESS: 1395 S. PINELLAS AVE. TARPON SPRINGS, FL. 34689. THE WRITTEN REVOCATION WILL NOT AFFECT ANY INFORMATION ALREADY DISCLOSED BY FLORIDA HOSPITAL NORTH PINELLAS PRIOR TO THE REVOCATION.

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