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

Please allow a minimum of three business days to process your request.

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 the Health Information Management department 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 redisclosure 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. Florida Hospital 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 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: ______________________

____ Last 4 of SSN: ______________________

Patient Phone Number: ____

I authorize Florida Hospital to: ☐Disclose to ☐Obtain from ____________________________________ and send to below requestor.

Name: ____ Address: ____

City: _________________________________ State: _________ Zip: _____________

Phone: ______________________________ Fax: ______________________

☐Paper ☐Email address: ____ ☐Other format (Contact HIM department directly)

I understand that all records will be mailed unless specified. ☐Pick Up at ___________________ Hospital

I am a patient receiving re-occurring treatment: ☐Yes ☐ No

Please furnish the following information specified below for the following Visit Dates: ________________________Check appropriate boxes below

☐Abstract of Record (Dictated Reports, laboratory, cardiology, radiology) ☐Emergency Department Records

☐Discharge Summary ☐Operative Report(s) ☐History & Physical ☐Laboratory Reports ☐Billing Records

☐Pathology Reports ☐Radiology Report(s) ☐ Complete chart ☐Other: ____________________________

Patient Signature: ____ Printed Patient Name:___________________________________

Legally Authorized Person Signature: ____________________________ Print Name:____

Witness Signature: ____ Print Name:____

Date :____________________________

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

If access is denied and patient requests review of denial, contact the Release of Information office below.

Medical Records released/accessed: Date of release/Access_____________________ By:___________________________________

Release of Information Contact Information Mailing Address only:
Florida Hospital Health Information Management
Release of Information
3100 E. Fletcher Ave.
Tampa, Fl. 33613
Phone 813-615-7292 Fax: 813-615-8337

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

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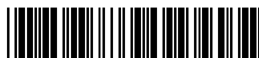
Tab: Authorization for release of information DH: Release of Information



Patient Name_________________________

FIN_____________ MRN______________

or Patient Label