AdventHealth

Please fill out completely

Patient Name:____________________ Date of Birth:________ MRN #: ________________
Address:________________________
City: _______________ State: ________ Zip code: ________ Contact Tel # __________

To be completed by requester: ☐ Pick Up ☐ Mail ☐ Other: ☐ E-Mail: ____________
If requested health information is needed for a doctor's appointment, please specify date: ______________

THE FOLLOWING INDIVIDUAL OR ORGANIZATION IS AUTHORIZED TO RELEASE THE FOLLOWING:

☐ AdventHealth Carrollwood ☐ AdventHealth North Pinellas ☐ AdventHealth Wesley Chapel
☐ AdventHealth Dade City ☐ AdventHealth Ocala ☐ AdventHealth Zephyrhills
☐ AdventHealth LTAC/Connerton ☐ AdventHealth Tampa ☐ AdventHealth Sebring
☐ AdventHealth Wauchula ☐ AdventHealth Lake Placid ☐ ____________

Admission/Discharge Date(s): ________________________

Forward to Health Information Management (Medical Records) for:

☐ *Abstract ☐ Discharge Summary ☐ Operative Report ☐ Emergency Room Report ☐ EKG
☐ Pathology Report ☐ History & Physical ☐ Laboratory Report ☐ Imaging Report
☐ Consultation ☐Other (specify) ________________________

Forward to Patient Business Office for: ☐ Billing Information
Forward to Cardiology Dept. for: ☐ Cath Lab Images
Forward to Radiology Dept. for: ☐ Imaging Exams (specify) ____________________

Reason for requesting information: ________________________

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

THIS INFORMATION MAY BE RELEASED TO AND USED BY THE FOLLOWING INDIVIDUAL OR ORGANIZATION:

Name: ________________________ Phone:____________
Address: ________________________ Fax: ____________
City: ______________ State: __________ Zip Code: ____________
Physician E-Mail:________________ Patient E-Mail:________________

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 Health Information Management Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. **Unless otherwise revoked, this authorization will expire on the following date, event or condition (not to exceed 1 year). If I fail to specify an expiration date, event or condition, this authorization will expire 1 year from the date signed**.

I understand that authorizing the release of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or obtain a copy of the information to be used or released, as provided in CFR 164.524. I understand that any release of information carries with it the potential for an unauthorized re-release and the information may not be protected by Federal confidentiality rules. If I have questions about release of my health information, I can contact the authorized individual or organization making disclosure.

I understand the information in my health record may include psychiatric, alcohol or drug abuse/testing information which may be protected by Federal and State Regulations. I also understand that my health record may include information relating to AIDS, HIV, and/or sexually transmitted disease, and all other sensitive information.

Patient Signature:________________________ Date: ____________

Authorized Representative/Parent:____________________ Date: ____________
Representative/Parent: ________________________

Printed Name of Authorized Person: ______________ Relationship to the patient: __________
*If access is being denied an additional denial document shall be provided to requestor

AUTHORIZATION FOR USE AND/OR DISCLOSURE AND REQUEST FOR ACCESS TO PROTECTED HEALTH INFORMATION

West Florida Division
rev. 09/19