

Authorization to Use or Disclose Protected Health Information

- | | | |
|---|---|---|
| <input type="checkbox"/> BayCare Alliant Hospital | <input type="checkbox"/> Morton Plant North Bay Hospital | <input type="checkbox"/> St. Joseph's Women's Hospital |
| <input type="checkbox"/> Mease Countryside Hospital | <input type="checkbox"/> St. Anthony's Hospital | <input type="checkbox"/> St. Joseph's Hospital – North |
| <input type="checkbox"/> Mease Dunedin Hospital | <input type="checkbox"/> St. Joseph's Hospital | <input type="checkbox"/> St. Joseph's Hospital – South |
| <input type="checkbox"/> Morton Plant Hospital | <input type="checkbox"/> St. Joseph's Children's Hospital | <input type="checkbox"/> South Florida Baptist Hospital |
| <input type="checkbox"/> _____ | | |

I hereby authorize the above hospital(s) to use or disclose the following information from the health records of the individual whose name is described below.

Patient Name: _____ Date of Birth: _____
 (Please Print)

Address: _____
 (City) (State) (Zip)

Phone Number: _____ Social Security # _____

I authorize the above hospital(s) to release medical, mental, alcohol and/or drug abuse, HIV (human immunodeficiency virus) testing, AIDS, eating disorders or any other medical information of a sensitive nature to the following individuals or organization(s):

Name: _____

Address: _____
 (City) (State) (Zip)

• This information for which I'm authorizing disclosure will be used for the following purpose:
 Description: _____

Dates of service to be released: _____

The type of information to be used or disclosed is as follows (check the appropriate boxes and include other information where indicated). **Copy medical records to** **Electronic medium or** **Paper**

- | | |
|---|--|
| <input type="checkbox"/> Abstract | <input type="checkbox"/> Progress Notes |
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Lab results / X-Ray and Imaging |
| <input type="checkbox"/> History and Physical Reports | <input type="checkbox"/> Emergency Room Reports |
| <input type="checkbox"/> Operative Reports | <input type="checkbox"/> Consultation Reports |
| <input type="checkbox"/> Other: (please describe) _____ | |

I understand that if the organization authorized to receive the information is not a health plan or healthcare provider, the release information may no longer be protected by Federal privacy regulations. I understand that I need not sign this authorization to ensure treatment. This authorization shall remain valid for six months from the date signed below.

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 department or facility listed on the authorization. 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.

Signed _____ Date _____
 Patient or Authorized Person, Parent Legal Guardian Executor Power of Attorney
 Photo ID checked

Witness: _____ Date: _____

Copied by: _____ Date: _____ Pages copied: _____