

## Authorization to Use or Disclose Protected Health Information

- |   |  |   |   |
|---|--|---|---|
| <input type="checkbox"/> BayCare Alliant Hospital       | <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"/> Bartow Regional Medical Center | <input type="checkbox"/> Morton Plant North Bay Hospital | <input type="checkbox"/> St. Joseph's Women's Hospital    | <input type="checkbox"/> Winter Haven Hospitals         |
| <input type="checkbox"/> Mease Countryside Hospital     | <input type="checkbox"/> St. Anthony's Hospital          | <input type="checkbox"/> St. Joseph's Hospital – North    | <input type="checkbox"/> _____                          |
| <input type="checkbox"/> Mease Dunedin Hospital         | <input type="checkbox"/> St. Joseph's Hospital           | <input type="checkbox"/> St. Joseph's Hospital – South    |   |

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):

**Patient Information (Please Print)**

First Name:		Middle Initial:		Last Name:	
Name at Time of Treatment (if different than above):					
Date of Birth (MM/DD/YYYY)			Phone:		
Street Address:		City:		State:	Zip:

**What records do you want? (Check appropriate boxes below):**

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

Description: \_\_\_\_\_

Date(s) of Service: \_\_\_\_/\_\_\_\_/\_\_\_\_ through \_\_\_\_/\_\_\_\_/\_\_\_\_

- Discharge Summary   
  Emergency Room Record   
  Operative/Procedure Report   
  Visit Summary   
  Billing Records  
 Test Results (X-Rays, Lab/Pathology Results) Please specify: \_\_\_\_\_  
 Other (Immunization Records, Medication Lists) Please specify: \_\_\_\_\_

**How would you like your records delivered? (Choose one)**

<input type="checkbox"/> Paper <input type="checkbox"/> CD <input type="checkbox"/> Mail   or <input type="checkbox"/> In-Person Pickup	<input type="checkbox"/> Electronic (Must have BayCare Patient Portal Account) <input type="checkbox"/> Patient Portal
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**Where do you want the information sent? (Fill in boxes below):**

Name:	Phone:
Mailing Address:	Fax:


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: \_\_\_\_\_

 <p><b>AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION</b> BC 4761</p>	<p><b>P A T I E N T</b></p>
Rev. 11/18	