Authorization to Use or Disclose Protected Health Information

Barlow Regional Medical Center Morton Plant North Bay Hospital St. Joseph's Hospital Winter Haven Hospitals Mease Countryside Hospital St. Joseph's Hospital St. J							
Mease Countryside Hospital	BayCare Alliant Hospital	☐ Morton Plant Ho	spital	☐ St. Joseph's Chi	ildren's Hospital 🔲 So	outh Florida Baptist Hospital	
Meuse Dumedin Hospital	Bartow Regional Medical Center Morton Plant North Bay Hospital			☐ St. Joseph's Women's Hospital ☐ Winter Haven Hospitals			
Tauthorize 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)	Mease Countryside Hospital St. Anthony's Hospital			St. Joseph's Hospital – North			
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:	Mease Dunedin Hospital St. Joseph's Hospital St. Joseph's Hospital				spital – South		
Name at Time of Treatment (if different than above): Date of Birth (MM/DD/YYYY) 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: Description: Description: 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) Paper CD Electronic (Must have BayCare Patient Portal Account) If you selected Mail or CD, where do you want the information sent? (Fill in boxes below): Name: Mailing Address: 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 is ensure treatment. This authorization is hall 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 Pevoke 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 more apply to information that as 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: Date: Date: Pages copied: PA T LEGALTHINFORMATION Pages copied: PA A T LEGALTHINFORMATION	AIDS, eating disorders or any o	other medical inform	nation of a sensit	ive nature to the fo	llowing individuals or	organization(s):	
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Patient or Authorized Person, Parent Legal Guardian Power of Attorney Photo ID checked Witness: Date: Copied by: Date: Pages copied: AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION Power of Attorney Pages copied: Pages cop	writing and present my written not apply to information that ha	revocation to the de as already been relea	partment or faci used in response	lity listed on the au to this authorization	thorization. I understand. I understand that the	nd that the revocation will e revocation will not apply	
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