

Authorization to Use or Disclose Protected Health Information



Instructions for Completing and Submitting the Form to the BayCare Central Business Office (CBO)

To have your request processed in a timely manner, please complete all fields.

- Enter the facility name on the first line, after “I hereby authorize _____”.
- All patient information fields must be completed and must match current patient account.
- Complete “I authorize ... release to the following individuals” (e.g. *self, insurance company, attorney*).
- Complete “This information ... used for the following purposes” (e.g. *personal needs, reimbursement, health spending account*).
- Enter the date of service and account number to be released (one account number per form).
- Check “other” box and indicate UB04 or HCFA1500.
- Sign and date the form.
- Check relationship field (*relationship between the patient and person signing*).
- Witness must sign and date the form.
- “Copied by” date is for internal use only.
- Submit completed form(s) to:
 - Fax: (727) 333-6176
 - Mail: BayCare CBO, Customer Service, P.O. Box 2369, Oldsmar, FL 34677
 - Email: cbocorrespondencerequest@baycare.org

Comments (internal use only):

Incomplete forms will not be processed. The incomplete form will be returned to the requestor.



Authorization to Use or Disclose Protected Health Information

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