Authorization to Use or Disclose Protected Health Information

☐ BayCare Alliant Hospital	☐ Morton Plant North Bay Hospital	☐ St. Joseph's Women's Hospital
☐ Mease Countryside Hospital	☐ St. Anthony's Hospital	☐ St. Joseph's Hospital – North
☐ Mease Dunedin Hospital	☐ St. Joseph's Hospital	☐ St. Joseph's Hospital – South
☐ Morton Plant Hospital	☐ St. Joseph's Children's Hospital	☐ South Florida Baptist Hospital

☐ _____

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**

☐ Abstract	☐ Progress Notes
☐ Discharge Summary	☐ Lab results / X-Ray and Imaging
☐ History and Physical Reports	☐ Emergency Room Reports
☐ Operative Reports	☐ Consultation Reports
☐ 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:_____

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION BC 4761 Rev. 12/14	**PATIENT**