

# 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: (813) 635-2653 or
  - Mail: BayCare CBO, Customer Service, P.O. Box 2369, Oldsmar, FL 34677

Comments (internal use only):

---

---

---

---

---

---

---

---

---

---

---

---

---

---

---

---

---

---

---

---

---

---

---

---

---

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

