

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ MR#: \_\_\_\_\_  
Address: \_\_\_\_\_ Phone #: \_\_\_\_\_ SS#: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

*To be completed by requester:*     Pick Up     Mail     Other: \_\_\_\_\_  
If requested health information is needed for a doctor's appointment please specify date: \_\_\_\_\_

**The following individual or organization is authorized to make the following disclosure:**

Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
Address: \_\_\_\_\_ Fax: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

**Admission/Discharge Date(s):** \_\_\_\_\_

**Forward to Health Information Management (Medical Records) for:**

\*Abstract     Discharge Summary     Operative Report     Emergency Room Report  
 Pathology Report     History & Physical     Laboratory Report     Radiology Report  
 Consultation     Other (specify) \_\_\_\_\_

**Forward to Patient Business Office for:**  Billing Information    **Forward to Cardiology Dept for:**  Cath Lab Films

**Forward to Radiology Dept for:**  X-ray films (specify) \_\_\_\_\_

**Reason for requesting information:** \_\_\_\_\_

*Requests may be subject to copying fee*

**This information may be disclosed to and used by the following individual or organization:**

Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
Address: \_\_\_\_\_ Fax: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

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 Health Information Management Department. 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. **Unless otherwise revoked, this authorization will expire on the following date, event or condition (not to exceed 90 days):** \_\_\_\_\_. **If I fail to specify an expiration date, event or condition, this authorization will expire 90 days from the date signed.**

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by Federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure.

**I understand the information in my health record may include psychiatric, alcohol or drug abuse/testing information which may be protected by Federal and State Regulations. I also understand that my health record may include information relating to AIDS, HIV, and/or sexually transmitted disease.**

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Authorized Representative/Parent: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name of Authorized Representative/Parent: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Address and Phone # of Authorized Representative/Parent: \_\_\_\_\_

\*Abstract consists of facesheet, discharge summary, history & physical, consults, operative notes, emergency record, lab, radiology, EKG reports, and pathology. (if available).

**AUTHORIZATION FOR USE AND/OR DISCLOSURE AND REQUEST FOR ACCESS TO PROTECTED HEALTH INFORMATION**

Florida Hospital Memorial Medical Center

Daytona     Oceanside

rev. 4/03

PATIENT ID LABEL

