Request for Access and Authorization for Use and/or Disclosure of Protected Health Information

Please allow a minimum of seven business days to process your request.

I understand that the protected health information specified below may include mental health, substance abuse (e.g., drugs, alcohol) HIV/AIDS status information, diagnostic and treatment records.

I have read and understand the following statements:

1. I may revoke this authorization at any time by notifying the Health Information Management department in writing.
2. I understand that my revocation does not affect any disclosure made prior to the revocation being received and processed.
3. I understand the information disclosed may be subject to redisclosure and no longer be protected by federal or state privacy laws.
4. I understand that I am signing this form voluntarily and I am signing this under my own free will. Florida Hospital will not condition my treatment, payment enrollment in health plans or my eligibility for benefits by signing this form.
5. I understand that I will receive a signed copy of this form.
6. I am the patient or Legally Authorized Person (LAP) and I understand and agree to the provisions of this form/authorization by signing below.
7. I understand that unless otherwise revoked, this authorization will expire upon the following date, event or condition:_____. If no expiration date, event or condition is noted this authorization will expire 1 year from the date signed.

☐ This authorization is valid for information created within 12 months after the date this authorization is signed, as well as past information.

I understand it is my responsibility to notify Florida Hospital to initiate follow-up requests based upon this standing authorization.

Patient's Legal Name: _____ Date of Birth:_____

Address: _____ Last 4 of SSN: _____

_____ MRN: _____

Patient Phone Number: _____

I authorize Florida Hospital to: ☐Disclose to ☐Obtain from _____ and send to below requestor.

Name: _____ Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

☐Email address (via secured server)_____

☐Paper (I understand that all records will be mailed unless specified)

☐Electronic

The purpose of this request:

☐ Personal Request ☐ Treatment (Continued Care) ☐Other: _____

Please furnish the following information specified below for the following Visit Dates: _____Check appropriate boxes below

☐Abstract of Record (Dictated Reports, Laboratory, Cardiology, Radiology Reports) ☐Emergency Physician Sheet

☐Discharge Summary ☐Operative Report(s) ☐History & Physical ☐Laboratory Results ☐Billing Records

☐Pathology Reports ☐Radiology Report(s) ☐ Radiology Image(s) ☐OT/PT/Speech Therapy

☐Other: _____

Patient Signature: _____ Printed Patient Name:_____

LAP Signature: _____ Print Name:_____

Witness Signature: _____ Print Name:_____

Date :_____

Request for Access has been: ☐Granted ☐Partially Denied ☐Denied

If access is denied and patient requests review of denial, contact the Release of Information office below.

Medical Records released/accessed: Date of release/Access_____ By:_____

Send to Release of Information:

Email: FH.HIM.CSC.Incoming.Faxes@flhosp.org **Fax**: 407-303-0633 Phone: 407-303-9175

Mailing address: Florida Hospital Health Information Management Release of Information

701 E. Altamonte Dr, Suite 2000 Altamonte Springs, FL 32701

You have the right to complain to the Office of Civil Rights. The following is the contact information:

Office of Civil Rights ~ U S Department of Health & Human Services 61 Forsyth Street, SW. Suite 3B70 Atlanta, GA 30323 ~ Phone# 404-562-7886; 404-331-2867 ~ Fax# 404-562-7881

Patient Name_____

FIN_____ MRN_____

or Patient Label