Patient Name: _____ Patient #: _____

Patient Address: _____ Date of Birth: _____
Street Apt #

_____ SSN #: XXX-XX- _____
City State Zip Code

Patient Phone Number: _____ Today's Date: _____

I hereby request: (please check all boxes that apply)

X Disclosure of my protected health information to the individual(s) specified below by Florida Hospital Medical Education Clinic

❑ Release of my records by individual(s) specified below to Florida Hospital Medical Education Clinic (FHC, FHCE, LH, OP, SS)

The purpose of this request:

X At my request

❑ Other (describe) _____

The description of the specific protected health information to be accessed and/or disclosed:

X My Medical Records for dates of service: All Medical Records

- ❑ Medical record
  - ❑ Most recent ❑ 3 months ❑ 6 months
- ❑ Consultation
- ❑ History & Physical
- ❑ Laboratory Report(s)
- ❑ My Billing Record(s) for date(s) of service: _____
- ❑ Radiology Report(s)
- ❑ Pathology Report(s)
- ❑ Operative Report(s)
- X Other (specify) All Medical Records

I authorize: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Phone Number: _____ FAX Number: _____

to disclose the protected health information specified above to:

Medicine Specialists/Florida Hospital
Address: 2501 N. Orange Avenue, suite 235
Phone Number: 407-303-7270 Fax Number: 407-303-2553

I have read and understand the following statements:

I understand that if I request a copy of the protected health information specified herein Medical Education Clinic may impose a reasonable, cost-based fee for such access.

I understand that if I am denied access to all or a portion of my protected health information, the protected health information that I have been denied access to may not be disclosed as authorized in this Form.

I understand that the protected health information specified above may include mental health, substance abuse (e.g., drugs, alcohol) and/or HIV/AIDS status information and treatment records. **IF I DO NOT WANT THIS PROTECTED HEALTH INFORMATION DISCLOSED, MY OPTION IS NOT TO SIGN THIS FORM.**

I understand this form is revocable, upon written notice to Medical Education Clinic but if I do, it will not have any effect on any actions Medical Education Clinic took before it received the revocation. Unless otherwise revoked, this authorization will expire on the following date, event, or condition Indefinitely. If I fail to specify an expiration date, event, or condition, this authorization will expire ninety (90) days from the date signed.

I understand that my authorized disclosure of protected health information to the individual specified above carries with it the potential for re-disclosure by such individual and may no longer be protected by the Federal privacy laws.

I understand that signing this form is completely voluntary and I am signing it under my own free will. I understand that Medical Education Clinic will not condition treatment, payment, enrollment in any health plans or my eligibility for benefits if I decide not to sign this Form.

By signing this Form, I hereby authorize and permit the use and/or disclosure of my protected health information for the limited purposes(s), and in the limited manner, described in the Form.

I understand I will receive a signed copy of this Form.

If this Form authorized the use and/or disclosure of psychotherapy notes, it may not be used to authorize the use and/or disclosure of any other protected health information.

X I AM THE PATIENT AND I UNDERSTAND AND AGREE TO THE PROVISIONS OF THIS FORM/AUTHORIZATION.

❑ I UNDERSTAND AND AGREE TO THE PROVISIONS OF THIS FORM ON BEHALF OF THE INDIVIDUAL INDICATED BELOW TO BE THE PATIENT. I HAVE SIGNED MY NAME INDIVIDUALLY AND IN MY CAPACITY AS THE LEGAL REPRESENTATIVE OF THE PATIENT AND I HAVE ATTACHED A COPY OF THE COURT ORDER DESIGNATING ME AS THE GUARDIAN OF THE PATIENT, OR DOCUMENTATION DESIGNATING ME AS THE LEGAL REPRESENTATIVE FOR THE PATIENT.

_____ _____
Printed Name of Patient **Patient's Signature**

_____ _____
Printed Name of Legal Representative **Legal Representative's Signature**

_____ _____
Printed Name of Witness **Witness' Signature**

_____
Date & Time

(FOR OFFICIAL USE ONLY)

Request for Release has been: ❑ Granted ❑ Partially Denied ❑ Denied
Medical Records released:

_____ _____
Date of Release By

Copy of this form provided to patient
Forwarded to Medical Education Clinic Billing Services for release of Billing Records:

Date of Forward _____ By _____

PLEASE SUBMIT A COPY TO THE INDIVIDUAL, WHEN ACCESS TO PROTECTED HEALTH INFORMATION IS PARTIALLY OR COMPLETELY DENIED

If request has been partially or completely denied, the reason for denial is:

- ❑ PHI is not part of the designated record set
- ❑ Federal law forbids making the PHI in question available to you for inspection (i.e.; CLIA or Privacy Act of 1974)
- ❑ PHI is psychotherapy notes
- ❑ PHI has been compiled for legal proceeding
- ❑ PHI was obtained under promise of confidentiality and access would be reasonably likely to reveal source of PHI
- ❑ PHI is temporarily unavailable because you have agreed to denial of access in connection with your agreement to participate in a research study
- ❑ Licensed health care professional determined access to PHI is reasonably likely to physically/emotionally harm you or others
- ❑ Licensed health care professional determined PHI identifies a third person who is reasonably likely to be physically, emotionally, or psychologically harmed if access to PHI is granted
- ❑ Licensed health care professional determined providing your personal representative access to PHI is reasonably likely to harm you
- ❑ We are acting under the direction of a correctional institution and allowing the inmate (you) to obtain a copy of PHI would jeopardize the health, safety, security, custody, or rehabilitation of you or another person at the correctional institution.
- ❑ PHI is not maintained at our health care facility
  - ❑ We do not know who maintains the PHI you requested
  - ❑ We reasonably believe the PHI you requested is maintained by (Contact Information):_____

If access is denied, and patient requests review of denial; contact:
Florida Hospital Medical Education Department
Attn: Director of Privacy
2501 N. Orange Ave, Ste. 235
Orlando, FL 32803
407-303-2849

You do have a right to complain to the Office of Civil Rights.
The following is the contact information:
Office for 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 (TDD)
FAX #: 407-562-7881