

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)
PHONE (772) 468-4470 FAX (772) 468-4510

Section A: This section must be completed for all Authorizations					
Patient Name:			Recipient's Name:		
Patient's Address			Recipient's Address		
City:	Date of Birth:	City:	<i>Special Instructions:</i>		
State:	Social Security # <i>Optional</i>	State:			
Zip:	Phone #: (home)	Zip:	Phone #: (home)		
	Phone#: (cell)		Phone#: (cell)		
This authorization expires in six months unless otherwise specified. <u>Enter Date or Event but not both.</u>					
Expiration Date:		Event:			
Purpose of disclosure: <input type="checkbox"/> Continued Care/ Dr. <input type="checkbox"/> Personal Records <input type="checkbox"/> Legal Purpose <input type="checkbox"/> Other, Please describe					
Description of information to be used or disclosed					
Is this request for psychotherapy notes? <input type="checkbox"/> Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. <input type="checkbox"/> No, then you may check as many items below as you need.					
Description:	Date(s):	Description:	Date(s):	Description:	Date(s):
<input type="checkbox"/> Medical record abstract <input type="checkbox"/> Admission form <input type="checkbox"/> Dictation reports <input type="checkbox"/> Physician orders <input type="checkbox"/> Intake/outtake <input type="checkbox"/> Clinical Test/Lab results <input type="checkbox"/> Medication Sheets		<input type="checkbox"/> Operative Information <input type="checkbox"/> Cath lab <input type="checkbox"/> Special test/therapy <input type="checkbox"/> Rhythm Strips <input type="checkbox"/> Nursing Information <input type="checkbox"/> Transfer forms <input type="checkbox"/> ER Information		<input type="checkbox"/> Labor/delivery sum. <input type="checkbox"/> OB nursing assess <input type="checkbox"/> Postpartum flow sheet <input type="checkbox"/> Billing record: <input type="checkbox"/> All PHI in medical record <input type="checkbox"/> Other: <input type="checkbox"/> Other:	
I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. _____ (Initial)					
I understand that:					
1. I may refuse to sign this authorization and that it is strictly voluntary.					
2. If I do not sign this form, my health care and the payment for my health care will not be affected unless stated otherwise in section C.					
3. I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.					
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed. I understand that I may see and obtain a copy the information described on this form, for a reasonable copy fee, if I ask for it.					
5. I get a copy of this form after I sign it.					
Section B: Is the Requester of this PHI another health plan or health care provider?					
If yes, the health plan or health care provider must complete Section B, otherwise skip to Section C.					
Medical Records that are requested for purposes other than continuation of care there is a \$1.00 per page charge in compliance with Florida Statue 395.3025.					
Will the requester receive financial or in-kind compensation in exchange for using or disclosing this information? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, describe:			What is the purpose or use of this disclosure?		
Section C: Signatures <i>[I have read the above and authorize the disclosure of the protected health information as stated.]</i>					
Signature of Patient/Guardian/Patient Representative:				Date:	
Print Name of Patient Representative:				Relationship to Patient:	

LAWNWOOD REGIONAL MEDICAL CENTER & HEART INSTITUTE
 & Treasure Coast Behavioral Health Care

PATIENT INFORMATION LABEL



ROI
 LRMC840-048_8/11