AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION FROM MEDICAL RECORD

PATIENT INFORMATION

This authorization is for the release of medical information.

PATIENT'S NAME _____
Last First M.I.

ADDRESS _____

BIRTH DATE _____/_____/_____ **DAYTIME TELEPHONE NUMBER** _____
Month Day Year

SOCIAL SECURITY NO. _____

ORGANIZATION PROVIDING INFORMATION:

_____
Name of person or organization **releasing** information

_____
Street Address

_____
City, State, Zip

ORGANIZATION REQUESTING INFORMATION:

_____
Name of person or **organization <u>requesting</u>** information

_____
Street Address

_____
City, State, Zip

INFORMATION TO BE DISCLOSED:

☐ Medical Notes/Summary ☐ Operative/Procedure Reports_____ ☐ Pathology_____

☐ PAP/HPV type ☐ Mammograms/Sonograms (report only, no films) ☐ Pelvic Sono ☐ Bone Density ☐ CXR / EKG

☐ Recent Lab ☐ All Medical Records – limited to 2 years ☐ Mammogram report, film & CD ☐ Other: _____

SPECIAL AUTHORIZATION TO DISCLOSE SUPER-CONFIDENTIAL INFORMATION:

ALCOHOL/DRUG/INFECTIOUS DISEASE/MENTAL HEALTH RECORDS are protected by Federal Regulation 42 CFR, Part 2. Release of such records requires specific consent. I hereby grant such specific consent as initialed below. **I UNDERSTAND** that these records are protected under federal and state law and cannot be disclosed without my written consent unless otherwise provided by law. I further understand that the specific type of information to be disclosed may, if applicable, include diagnosis, prognosis, and treatment for physical and/or mental illness including treatment of alcohol or substance abuse, sexually transmitted diseases, acquired immune deficiency syndrome (AIDS), or human immunodeficiency virus (HIV) infection.

AS PART OF THE MEDICAL RECORDS CHECKED ABOVE, THE FOLLOWING INFORMATION WILL BE RELEASED UNLESS STRICKEN:

HIV/AIDS related information and/or records Mental Health information and/or records

Sexually transmitted diseases Drug/alcohol diagnosis, treatment or referral information

SIGNATURE: _____ **DATE**: _____
Patient or legal representative

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PURPOSE OF DISCLOSURE:

☐ Continuing medical treatment ☐ Residence Relocation ☐ Second Opinion ☐ Patient Request

For purposes other than Treatment, Payment and Operations:
(Patient is to receive a copy of the Authorization)

☐ Research ☐ Disability Insurance ☐ FMLA ☐ Life Insurance

☐ Marketing Promotion: I have been informed **River City OBGYN** __is __ is not receiving any direct or indirect compensation from a third party as a result of disclosing information for this purpose.

☐ Sale of PHI: I have been informed that **River City OBGYN** __is __ is not receiving any direct or indirect compensation from a third party as a result of disclosing information for this purpose.

☐ Other (please specify): _____

I understand that this authorization will expire **one year** from the date of signature below.

RIGHT TO REVOKE AUTHORIZATION:

I MAY REVOKE THIS AUTHORIZATION AT ANY TIME, IN WRITING, BEFORE THE INFORMATION HAS BEEN RELEASED. I FURTHER UNDERSTAND THAT I HAVE A RIGHT TO RECEIVE A COPY OF THIS AUTHORIZATION UPON REQUEST. I HEREBY RELEASE **River City OBGYN** FROM ANY AND ALL LEGAL LIABILITY THAT MAY ARISE FROM THE RELEASE OF THIS INFORMATION TO THE PARTY NAMED ABOVE.

AUTHORIZATION & SIGNATURE:

I hereby authorize the use of disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that treatment, payment, enrollment or eligibility of benefits may not be conditioned on my signing this authorization. I further understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information could potentially be redisclosed and may no longer be protected by federal privacy regulations. Therefore, I release **River City OBGYN** from all liability arising from this disclosure of my health information.

I understand and agree that I am financially responsible for the following fees associated with my request: copying charges and postage related to the production of my information. *For patients and governmental entities*: 1.00 per page for the first 25 pages and 25¢ per page for each page in excess of the first 25 pages. *For other entities*: up to $1.00 per page for each page copied, in accordance with Florida Administrative Code 64B8-10.003.

BY SIGNING THIS AGREEMENT, I ACKNOWLEDGE THAT I HAVE CAREFULLY READ, UNDERSTAND AND AGREE TO THE ABOVE TERMS AND CONDITIONS.

Printed Name of Patient: _____ Date: _____

Patient Signature: _____ Social Security #:_____

Printed Name of Parent, Guardian or Legal Representative:_____

Parent, Guardian or Legal Representative Signature:_____ -_____

Relationship to Patient:_____ **Records are needed by**:_____(date)

Send by: **Fax_____** (Patient must initial approval) **Mail** **Patient will pick up** **Electronic format if EMR**