

AUTHORIZATION TO REQUEST PROTECTED HEALTH INFORMATION (PHI)
FLORIDA HEALTH CARE PLANS • P.O. BOX 9910 • DAYTONA BEACH, FL 32120
PLEASE FAX MEDICAL RECORDS TO: 386-481-5009 OR 888-427-4544

FHCP Medical Record #: _____ Birth Date: _____

Patient Name and Maiden Name: _____ Social Security # _____

Address: _____

Home Phone #: _____ Work #: _____

I hereby authorize FHCP to obtain my previous medical records from:

Facility/Provider: _____ Phone# _____ Fax# _____

STREET ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____

Purpose for release:	<input type="checkbox"/> Continuing Care	<input type="checkbox"/> Legal	<input type="checkbox"/> Insurance	<input type="checkbox"/> Patient Request	<input type="checkbox"/> Other
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Please release the following information contained in my medical records regarding my care/treatment to FHCP:

<input type="checkbox"/> All Records	<input type="checkbox"/> Office Visits	<input type="checkbox"/> Operative Reports	<input type="checkbox"/> Labs/Date drawn _____
<input type="checkbox"/> Immunizations	<input type="checkbox"/> Radiology Reports	<input type="checkbox"/> Other _____	

Date(s) of Service: _____

I understand that all of my medical records may be faxed to FHCP unless specified here - Mail (above P.O.Box)

If a Sensitive Information box is checked below, the patient must initial to authorize the release of this information.

<input type="checkbox"/> HIV/AIDS information _____	<input type="checkbox"/> Drug and Alcohol _____	<input type="checkbox"/> Psychiatric _____	<input type="checkbox"/> Other _____
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I understand that this authorization extends to all or any part of my records, which may include psychiatric, alcohol/drug, and/or AIDS (Acquired Immunodeficiency Syndrome) information, and may include the result of an HIV test or the fact an HIV test was performed. I expressly consent to the release of information as designated above. I understand this authorization extends to release information via U.S. mail, telephone, or facsimile machine (fax) or any other FHCP approved means. **I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization that I must do so in writing and present my written revocation to an FHCP Medical Records Department. I understand that the revocation will not apply to information that has already been released as requested by this authorization. I understand that any disclosure of information carries with it the potential for redisclosure where confidentiality laws or regulations may not apply. It also prohibits FHCP from making any further disclosure without the specific written authorization of the person to whom it pertains. I understand that FHCP will not condition treatment, payment, enrollment, or eligibility for benefits on whether or not I sign this authorization.**

Release of PHI Request Expiration Date: (Must check a box or enter an "Expiration Date")
<input type="checkbox"/> Upon Death Or Expiration Date / / Or <input type="checkbox"/> one year from the date of signature

Signature of Patient or Legal Representative/Authorized Health Surrogate* _____ Date

Witness _____ Date

*Legal Representative/Authorized Health Care Surrogate is defined as a court appointed guardian or personal representative, a person with a Health Care Power of Attorney specific to medical records access, a person designated as a Health Care Surrogate, or next of kin. Supporting documentation required.