

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION (PHI)



P.O. BOX 9910
DAYTONA BEACH, FL 32120

Medical Records FAX:
386-481-5009 OR
888-427-4544

I. PATIENT INFORMATION

Patient Name: _____	Date of Birth: _____
Address: _____	Social Security # (last 4): _____
	Home Telephone #: _____
FHCP MRN #: _____	Cellular Telephone #: _____
Email Address: _____	Work Telephone #: _____

II. PROVIDER/FACILITY AUTHORIZED TO RELEASE PHI

Name: _____
Address: _____
Phone # _____ Fax #: _____

III. PERSON/FACILITY AUTHORIZED TO OBTAIN PHI

Name: _____	Relationship to Patient: _____
Address: _____	
Phone #: _____	Fax #: _____
Email Address: _____	

IV. PHI REQUEST AND DELIVERY INFORMATION

Date(s) of Service or Date Range for Release: _____
Record Type(s): <input type="checkbox"/> Office Visits <input type="checkbox"/> Immunizations <input type="checkbox"/> Operative <input type="checkbox"/> Radiology Report
<input type="checkbox"/> Labs-Date Drawn (specify): _____ <input type="checkbox"/> Other (specify): _____
Purpose: <input type="checkbox"/> Continuing Care <input type="checkbox"/> Legal <input type="checkbox"/> Insurance <input type="checkbox"/> Patient <input type="checkbox"/> Other (specify): _____
Requested Format: <input type="checkbox"/> Paper <input type="checkbox"/> Electronic (CD or Email – Please Circle) <input type="checkbox"/> Verbal
Delivery Method: <input type="checkbox"/> Mail <input type="checkbox"/> Email (if possible) <input type="checkbox"/> Pick up <input type="checkbox"/> Fax (Medical Facilities Only)

V. APPROVAL OF RELEASE OF SENSITIVE PHI

Check and initial to approve disclosure of any PHI that may contain information pertaining to:			
<input type="checkbox"/> HIV/AIDS:	<input type="checkbox"/> Drug /Alcohol:	<input type="checkbox"/> Psychiatric:	<input type="checkbox"/> Genetic Counseling/Testing:

I understand that this authorization extends to all or any part of my records, which may include psychiatric, alcohol/drug, genetic counseling/testing, and/or AIDS (Acquired Immunodeficiency Syndrome) information, any 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 that I have the right to revoke this authorization at any time and that if I revoke this authorization that I must do so in writing and present my written revocation to FHCP Medical Records Department. I understand that the revocation will not apply to PHI that has already been released as requested by this authorization. I understand that any disclosure of PHI 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.**

VI. RELEASE OF PHI EXPIRATION DATE (MUST EITHER CIRCLE OR ENTER)

<input type="checkbox"/> Upon Death	OR	<input type="checkbox"/> Expiration Date: / /	OR	<input type="checkbox"/> One year from signature date.
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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.

Completed form can be returned by mail to the address at the top of this page, by fax to the number(s) at the top of this page, or scanned and sent by email to medrecroi@fhcp.com.