Authorization to Release Protected Health Information

Patient Information

Patient Name: _____ Date of Request: _____

Patient Address: _____
Street City State Zip

Patient Phone Number: _____ Date of Birth: _____ Last 4 of SSN: _____

Medical Record Number: _____

I am requesting Health First:

❒ **Disclose/release to:**

Name: _____

Address: _____
Street City State Zip

Phone: _____ Fax: _____

For physicians and other healthcare providers only

OR

❒ **Obtain my health information/medical record from: (fees may apply)**

- ❒ Health First Medical Group Facility
- ❒ Health First's Palm Bay Hospital
- ❒ Health First's Cape Canaveral Hospital
- ❒ Health First's Holmes Regional Medical Center
- ❒ Health First's Viera Hospital
- ❒ Other (specify): _____

The type of information to be used or disclosed is as follows:
(check the appropriate boxes and add other information where indicated)

- ❒ Abstract
- ❒ Discharge Summary
- ❒ Operative Report
- ❒ Entire Medical Record
- ❒ Progress Notes
- ❒ History & Physical
- ❒ Cardiology Reports
- ❒ Cardiology Images
- ❒ Radiology Reports
- ❒ Office/Clinic Notes
- ❒ ED Record
- ❒ Radiology Images
- ❒ Lab (specify dates): _____
- ❒ Physician Orders: _____

Service Dates Requested: _____

❒ Paper ❒ Electronic (CD, if available) ❒ Fax (for physicians and other healthcare providers only)

❒ Records to be mailed

❒ Pick up (allow 48 hours to process): ❒ by patient or ❒ by designated person

Name of designated: _____ (photo ID required)

This information for which I am authorizing disclosure will be used for the following purpose(s):

❒ Personal Records ❒ Legal Purposes ❒ Insurance ❒ Continued Care

❒ Other (specify): _____

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Authorization:

I authorize Health First, Inc., and the entity indicated to make the disclosures as specified.

I understand the health record may include information relating to Sexually Transmitted Diseases (STDs), Acquired Immunodeficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV). It may also include information about behavioral or mental health services, as well as treatment for alcohol and drug abuse. If I do not want these items released, I will indicate that on this form.

I understand I can cancel or take back (revoke) this authorization in writing, to the Health First Health Information Management Department (Medical Records) at the address below. I understand actions already taken based upon this form cannot be revoked. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

I understand unless revoked, this authorization will expire six months from the date it was signed or the date as specified by me:

_____.
Date

I understand once the above information is disclosed, it may be redisclosed by the recipient and is no longer protected by federal privacy laws or regulations.

I understand authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment.

If I have questions about disclosure of my health information, I can contact the Health First Health Information Management Department (Medical Records) at the location listed below.

❒ I am the patient and understand and agree to the provisions of this authorization.

❒ I understand and agree to the provisions of this authorization as the patient's legal representative.

_____
Print patient name

_____ _____
Signature of patient or legal representative **Date**

* If signed by legal representative, relationship to patient: _____

* Documentation provided establishing relationship (specify document): _____

_____ _____
Signature of witness **Date**

FOR OFFICE USE ONLY

Request for access/disclosure has been: ❒ Granted ❒ Partially Granted ❒ Denied

If access/disclosure denied and patient requests review of denial, contact the Health Information Management office listed below.

Request verified and processed by: _____ _____
Universal ID Date

Form of ID presented for verification: ❒ Driver's license ❒ Government ID ❒ Other (specify) _____

Health Information Management Department
1350 S. Hickory St., Melbourne, FL 32901
Phone: 321.434.7169 Fax:321.434.5239

Health First Medical Group
1223 Gateway Dr., Melbourne, FL 32901
Phone: 321.725.4500 ext. 7307 Fax: 321.724.8069