Authorization to Release Protected Health Information

Patient Information

Patient Name _____ Date of Request _____

Patient Phone_____ Date of Birth _____

Last 4 digits of SSN _____ Medical Record Number_____

I am requesting that Health First: ☐ Disclose (Release) to: **-OR-** ☐ Obtain from: my health information (medical record):

Name_____

Address_____

City _____ State_____ Zip_____

Phone _____ Fax (for healthcare providers only)_____

Information Requested (Fees may apply)

☐ Health First's Cape Canaveral Hospital ☐ Health First's Holmes Regional Medical Center ☐ Health First's Palm Bay Hospital

☐ Health First's Viera Hospital ☐ Health First Medical Group

☐ 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
☐ History and physical
☐ Discharge summary
☐ Operative report
☐ Entire medical record
☐ ED record
☐ Cardiology reports
☐ Cardiology images
☐ Physician orders
☐ Progress notes
☐ Radiology reports
☐ Radiology images
☐ Office/Clinic notes
☐ Lab - Specify dates:_____

Service Dates Requested: _____

☐ Paper ☐ Electronic (CD) (if available) ☐ Fax (for healthcare providers only)
☐ Records to be mailed
☐ Pick up (Allow 48 hours to process): ☐ By patient
☐ By designated person, name_____
(Photo ID required for pick up)

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) _____

Health First's Cape Canaveral Hospital, Cocoa Beach, FL
Health First's Holmes Regional Medical Center, Melbourne, FL
Health First's Palm Bay Hospital, Palm Bay, FL
Health First's Viera Hospital, Viera, FL
Health First Medical Group

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Authorization

I authorize Health First, Inc. and the entity indicated above to make the disclosure as specified on page one.

I understand that the health record may include information relating to sexually transmitted disease, acquired immune deficiency syndrome (AIDS), or human immune-deficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse. If I do not want these items released, I will indicate that on this form.

I understand that I can cancel or take back (revoke) this authorization in writing, to the Health Information Management (HIM) Department, except for actions already taken based upon it. I understand that 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 that unless revoked, this authorization will expire six months from the date it was signed or the date as specified by me _____.

I understand that once the above information is disclosed, it may be redisclosed by the recipient and 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 HIM 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.

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_____

Main Health Information Management Department Locations:	
Health First's Holmes Regional Medical Center 1350 S. Hickory St., Melbourne, FL 32901 **Phone** 321.434.3288 | **Fax** 321.434.5027	**Health First Medical Group (HFMG)** 730 Malabar Road., Malabar, FL 32950 **Phone** 321.549.0695 | **Fax** 321.724.8069

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 **above**.

Request verified and processed by: Universal ID _____ Date_____

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

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