FF002700

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Patient Information

Patient Name: _____ Date of Request: _____

Patient Address: _____

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 physicians/other healthcare providers only)

Information Requested (Fees may apply)

☐ HFMG ☐ Holmes Regional Med Center ☐ Palm Bay Hospital ☐ Viera Hospital ☐ Cape Canaveral Hospital

☐ Other (Specify): _____

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

☐ Abstract	☐ ED Record	☐ Radiology Reports
☐ History & Physical	☐ Cardiology Reports	☐ Radiology Images
☐ Discharge Summary	☐ Cardiology Images	☐ Office/clinic notes
☐ Operative Report	☐ Physician Orders	☐ Lab - Specify dates: _____
☐ Entire Medical Record	☐ Progress Notes	

Service Dates Requested: _____

☐ Paper ☐ Electronic (CD) (if available) ☐ Fax (for physicians/other healthcare providers only)

☐ Records to be mailed

☐ Pick up (Allow 48 hrs. 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 _____

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Authorization

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

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 _____

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, Florida 32901
Phone: 434-7169
Fax: 434- 5239

Health First Medical Group
1223 Gateway Dr.
Melbourne, FL 32901
Phone: 321-725-4500 ext: 7307
Fax: 321-724-8069

Health First

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

10/15
Revised: