Authorization for Use and Disclosure of Protected Health Information (PHI)

Genesis Women's Center (352)726-7667 Fax (352)726-8193

Patient Legal Name	*Birthdate*	*Social Security No. (optional)*
Address		*Telephone No.*
City	*State*	*Zip Code*

I hereby authorize, _____

Facility or Covered Entity

_____, to disclose medical record information

Phone *Fax*

and/or protected health information of the patient listed above to:

_____

Name/Title *Phone* *Fax*

_____

Address

Purpose: _____

For treatment date: _____

Type of Access Requested:

- ❒ Copies of the record
- ❒ Inspection of the record
- ❒ Verbal disclosure of patient information

Selected Portions of PHI:

- ❒ Entire Record
- ❒ Abstract/Pertinent
- ❒ Dictated Reports
- ❒ History and Physical
- ❒ Discharge Summary
- ❒ Operative Report
- ❒ Emergency Room
- ❒ Lab
- ❒ Imaging/Radiology
- ❒ Cardiac Studies
- ❒ Face Sheet
- ❒ Consult Report
- ❒ Progress Notes
- ❒ Physician Orders
- ❒ Anesthesia Record
- ❒ Other _____

_____

_____

_____ ***Initials*** **I acknowledge, and hereby consent to such, that the release information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results, or AIDS information.**

Expiration: This authorization shall expire upon date of signature unless otherwise specified.

Date or Event: _____

1. **I understand that this authorization may be revoked by me in writing at any time except to the extent that action has been taken in reliance upon it.**
2. **I understand that treatment and payment may not be conditioned on obtaining this authorization. The information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer protected.**
3. **Fees/charges will comply with all laws and regulations applicable to release of information.**
4. **I have read the above and authorize the disclosure of the protected health information as stated.**

_____ _____ _____

Date ***Signature of Patient/Parent/Patient Representative*** ***Relationship to Patient***

_____ _____

Date ***Printed name of Patient/Parent/Patient Representative***

_____

Address and telephone number of Requestor (if different from patient information)

NOTE: A fee will be charged to the patient when they request their records for personal use. However, no fee will be charged if records are sent directly to another continuing care provider (e.g. other physician, hospital, or clinic).