

Authorization to Release Protected Health Information

Patient Information

Patient Name: _____ Date of Request: _____

Patient Address: _____
Street City State ZIP

Patient Phone Number: _____ DOB: _____ 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)

- | | |
|---|--|
| <input type="checkbox"/> Health First Medical Group Facility | <input type="checkbox"/> Health First's Holmes Regional Medical Center |
| <input type="checkbox"/> Health First's Palm Bay Hospital | <input type="checkbox"/> Health First's Viera Hospital |
| <input type="checkbox"/> Health First's Cape Canaveral Hospital | <input type="checkbox"/> Other (specify): _____ |

The type of information to be used or disclosed is as follows:

(check the appropriate boxes and add other information where indicated)

- | | | |
|--|--|---|
| <input type="checkbox"/> Abstract | <input type="checkbox"/> History & Physical | <input type="checkbox"/> ED Record |
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Cardiology Reports | <input type="checkbox"/> Radiology Images |
| <input type="checkbox"/> Operative Report | <input type="checkbox"/> Cardiology Images | <input type="checkbox"/> Lab (specify dates): _____ |
| <input type="checkbox"/> Entire Medical Record | <input type="checkbox"/> Radiology Reports | <input type="checkbox"/> Physician Orders: _____ |
| <input type="checkbox"/> Progress Notes | <input type="checkbox"/> Office/Clinic Notes | |

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): _____

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 First
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 Drive, Melbourne, FL 32901
 Phone: 321.725.4500 ext. 7307 | Fax: 321.724.8069