Florida Medical Center
A STEWARD FAMILY HOSPITAL
Steward

5000 W. OAKLAND PARK BLVD., FT. LAUDERDALE, FL 33313
HEALTH INFORMATION MANAGEMENT DEPARTMENT
PHONE: 954-730-2830 FAX: 954-730-2803

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

Patient's Name: _____
Last First Middle

Home Address: _____

Home Telephone: _____ Date of Birth: _____

SPECIFY INFORMATION TO BE DISCLOSED**: The information that may be disclosed under this Authorization includes**:

☐ Discharge ☐ Pathology ☐ Emergency
☐ History & Physical ☐ Radiology ☐ Holter Monitor Reports
☐ Consultations ☐ Laboratory ☐ Rehab (PT, OT, ST)
☐ Operative Reports ☐ ECHO / EEG / EKG (circle) ☐ Mammogram Report ☐ Other

Please provide date of service being requested: _____

MY HIGHLY CONFIDENTIAL INFORMATION:

By checking any of the boxes next to a category of highly confidential information listed below, I specifically authorize the use and/or disclosure of the category of highly confidential information indicated next to the box, if any such information will be used or disclosed pursuant to this Authorization:

☐ Information about mental health or mental retardation services

☐ Psychotherapy Notes created by a mental health professional

☐ Information about HIV/AIDS-related testing (including the fact than an HIV test was ordered, performed or reported, regardless of whether the results of such tests were positive or negative)

☐ Information about sexually transmitted diseases

☐ Information about alcohol or drug abuse treatment program services

☐ Information about sexual assault

☐ Information about child abuse and neglect **OR** ☐ Abuse of an adult with a disability

RECEIPENT: **Name of person or class of persons to whom Florida Medical Center may disclose my health information**:

Address of the recipient or where my health information should be delivered: _____

☐ Do Not Mail: records will be picked up (if mailed, enclose a valid government issued picture ID)

TERM: **This Authorization will remain in effect**:

☐ **From the date of this Authorization until the _____ day of _____, 20_____.**

☐ **Until Florida Medical Center fulfills this request**.

☐ **Until the following event occurs**: _____

☐ **Other**: _____

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PURPOSE: **I authorize Florida Medical Center to use or disclose my health information (including the highly confidential information I selected above, if any) during the term of this Authorization for the following specific purpose(s)**: [Note: "at the request of the Patient" is sufficient if the Patient is initiating this Authorization] _____

I understand that once Florida Medical Center discloses my health information to the recipient, Florida Medical Center cannot guarantee that the recipient will not re-disclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.

I understand that Florida Medical Center may, directly or indirectly, receive remuneration from a third party in connection with the use or disclosure of my health information.

I understand that may refuse to sign or may revoke (at any time) this Authorization for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of my treatment at Florida Medical Center except, however, if my treatment at Florida Medical Center is for the sole purpose of creating health information for disclosure to the recipient identified in this Authorization, in which case Florida Medical Center may refuse to treat me if I do not sign this Authorization.

I understand that this Authorization will remain in effect until the term of this Authorization expires or I provide a written notice of revocation to **Florida Medical Center's** Privacy Office at the address listed below. The revocation will be effective immediately upon **Florida Medical Center's** receipt of my written notice, except that the revocation will not have any effect on any action taken by **Florida Medical Center** in reliance on this Authorization before it received my written notice of revocation.

I may contact hospital's Privacy Officer by mail at the Health Information Management Department, 5000 W. Oakland Park Blvd, Ft. Lauderdale, FL 33313 **OR** by telephone at (954) 730-2830, Extension 4042.

I have read and understand the terms of this Authorization and I have had an opportunity to ask questions about the use and disclosure of my health information. By my signature, I hereby knowingly and voluntarily authorize Florida Medical Center to use or disclose my health information in the manner described above.

_____ _____

Signature of Patient **Date**

Note: If Patient is a minor or is otherwise unable to sign this Authorization, obtain the following signatures:

_____ _____ _____

Signature of Authorized Personal Representative Relationship to Patient Date

For Internal Use Only: The identity of the requestor has been validated either with a government issued picture ID, such as a driver's license or passport, or comparison of signatures documented in the PHI records.

_____

Signature of Employee Validating Identity Patient's Medical Record Number

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CONSENT FOR EMAIL COMMUNICATION OF PATIENT HEALTH INFORMATION

As a health care provider, providing access to your records in a secure manner while balancing ease of access is important to us. You have requested that we transmit a copy of your records, which may contain your Protected Health Information (PHI), via email. We are required by law to notify you that email is not a completely secure means of communication due to the fact that messages can be addressed to the wrong person or messages can be intercepted during transmission by a third party.

If you acknowledge the above risks and still would like for us to send your information via email, please print clearly, sign and complete the consent below. You are not required to authorize the use of email, and any decision not to sign this form will not impact your health care or treatment at this provider. Please note – due to some email providers, certain size files may not be transmitted. In the event that there is trouble with transmission, we will place your records on a CD and mail them to you.

I acknowledge the above risks and consent to the use of email to distribute my Protected Health Information (PHI).

Printed Name: _____

Medical Record Number: _____

Date: _____

Signature: _____

Email Address to send PHI/Medical Records: _____

Home Address: _____

_____