Florida Medical Center
Patient Request /Authorization to Use and/or Disclose Protected Health Information

7) EXCLUSION REQUEST:
I request that the following admission(s) / visit(s) be specifically excluded from this request _____ (specify dates of service)

8) PURPOSE OF THE DISCLOSURE:
☐ Medical Care ☐ Legal ☐ Insurance ☐ Personal ☐ Other_____
*fees may apply

9) TERM: This Authorization will remain in effect for one year or:

☐ Until **Florida Medical Center** fulfills this request.
☐ From the date of this Authorization until the _____day of_____20_____
☐ Until the following event occurs:_____
☐ Other: _____

10) REVOCATION: I understand that I may revoke this Authorization at any time by requesting it of **Florida Medical Center** in writing at the address listed below. The revocation will be effective immediately upon **Florida Medical Center** receipt of my written notice. I understand that the revocation will not have any effect on any action taken by **Florida Medical Center** reliance on this Authorization before it received my written notice of revocation.

Attention Health Information Management
Florida Medical Center
5000 West Oakland Park Boulevard
Ft. Lauderdale, FL 33313

11) EFFECT ON TREATMENT/PAYMENT/ENROLLMENT/ELIGIBILITY: I understand that I may refuse to sign this Authorization for any reason and that such refusal will not affect the commencement, continuation or quality of my treatment, payment, health plan enrollment or eligibility for benefits at **Florida Medical Center**.

12) POTENTIAL FOR REDISCLOSURE: I understand that the person receiving my Protected Health Information may not be required to comply with federal and state privacy laws, and my Protected Health Information may no longer be protected by the applicable state and federal law once it is disclosed by **Florida Medical Center**.

13) ACCESS: I understand that in certain circumstances **Florida Medical Center** has the right to deny me access to all or portions of my Protected Health Information **Florida Medical Center** will notify me in writing of any such denials.

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

14) _____ _____
Signature of Patient Date

_____
Printed Name of Patient Witness

For Office Use:
☐ I.D Verification_____

Authorized patient representative signature. If the patient is a minor or is otherwise unable to sign this Authorization:

15) _____ _____
Signature of Personal Representative Date

_____ _____
Printed name of Patient Representative Relationship to patient or authority to act for patient

Questions about the release should be directed to the hospital HIM Director.

For Office Use:
☐ Copy of this authorization provided to the patient
☐ Copy of this authorization provided to the personal representative

IMPORTANT: THIS AUTHORIZATION IS NOT VALID UNLESS ALL APPLICABLE ENTRIES ARE COMPLETED AND FORM IS SIGNED ON PAGE 2

Signature of Personnel Completing Request | Print Name | Date | Time

Hialeah Hospital
Patient Request /Authorization to Use and/or Disclose Protected Health Information

7) EXCLUSION REQUEST:
I request that the following admission(s) / visit(s) be specifically excluded from this request _____ (specify dates of service)

8) PURPOSE OF THE DISCLOSURE:
❑ Medical Care ❑ Legal ❑ Insurance ❑ Personal ❑ Other_____
*fees may apply

9) TERM: This Authorization will remain in effect for one year or:

❑ Until **Hialeah Hospital** fulfills this request.
❑ From the date of this Authorization until the _____day of_____20_____
❑ Until the following event occurs:_____
❑ Other: _____

10) REVOCATION: I understand that I may revoke this Authorization at any time by requesting it of **Hialeah Hospital** in writing at the address listed below. The revocation will be effective immediately upon **Hialeah Hospital** receipt of my written notice. I understand that the revocation will not have any effect on any action taken by **Hialeah Hospital** reliance on this Authorization before it received my written notice of revocation.

Attention Health Information Management
Hialeah Hospital
651 East 25th Street,
Hialeah, FL 33013

11) EFFECT ON TREATMENT/PAYMENT/ENROLLMENT/ELIGIBILITY: I understand that I may refuse to sign this Authorization for any reason and that such refusal will not affect the commencement, continuation or quality of my treatment, payment, health plan enrollment or eligibility for benefits at **Hialeah Hospital**.

12) POTENTIAL FOR REDISCLOSURE: I understand that the person receiving my Protected Health Information may not be required to comply with federal and state privacy laws, and my Protected Health Information may no longer be protected by the applicable state and federal law once it is disclosed by **Hialeah Hospital**.

13) ACCESS: I understand that in certain circumstances **Hialeah Hospital** has the right to deny me access to all or portions of my Protected Health Information **Hialeah Hospital** will notify me in writing of any such denials.

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

14) _____ _____
Signature of Patient Date

_____
Printed Name of Patient Witness

For Office Use:
❑ I.D Verification_____

Authorized patient representative signature. If the patient is a minor or is otherwise unable to sign this Authorization:

15) _____ _____
Signature of Personal Representative Date

_____ **15)**_____
Printed name of Patient Representative Relationship to patient or authority to act for patient

Questions about the release should be directed to the hospital HIM Director.

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