AUTHORIZATION TO USE AND/OR DISCLOSE PROTECTED HEALTH INFORMATION

☐ Request Completed by (staff initial): _____ Medical Record #: _____

I hereby authorize Rockledge Regional Medical Center to use and/or disclose the Protected Health Information specified below from my medical records.

1. Patient Name (Please Print): _____ Date of Birth: _____

   Address: _____
   Street City State Zip

   Contact Telephone Number(s): _____

2. Information to be disclosed to:

   _____
   Person or Facility Name (Please Print)

   _____
   Address (Please Print) City State Zip

   Fax #: _____

   Phone #: _____

3. Treatment Dates: From: _____ To: _____

4. Specific Records/Report(s) to be Released:

   ☐ Admission History and Physical ☐ Laboratory Results ☐ Rehab Services (PT, OT, Speech)
   ☐ Discharge Summary ☐ Imaging Reports (CT, X-Ray, MRI) ☐ Other
   ☐ Emergency Room ☐ Pathology Reports _____
   ☐ EKG Reports ☐ Operative Notes _____

5. Restricted Release: We will **not** disclose the following documentation **unless** you check the box and provide an additional signature:

Release	Signature	Release	Signature
☐ Mental/Behavioral Health Provider Documentation*		☐ Genetic Testing/Test Results**	
☐ HIV/AIDS Screening Test Results		☐ Alcohol*** and/or ☐ Substance Abuse Treatment***	
☐ Confidential Communication with a Social Worker		☐ Child/Elder Abuse and Neglect	
☐ Rape/Sexual Assault Victim's Counseling		☐ Domestic Violence Victim's Counseling	
☐ Sexually Transmitted Disease			

* This authorization is not valid for use or disclosure of psychotherapy notes.

** The term "genetic tests" means only those tests which determine your future chances of developing a disease, not tests done to diagnose a current condition or problem.

*** Only applicable to records that are created by an "individual or entity who holds itself out as providing alcohol or drug abuse diagnosis, treatment, or referral for treatment" (42 CFR Part 2). Does not include records created or maintained by a general medical facility.

6. Exclusion Request:

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

   _____

PATIENT IDENTIFICATION

7. Purpose of the Disclosure:
   ☐ Medical Care ☐ Legal ☐ Insurance ☐ Personal ☐ Other: _____

8. Term: This Authorization will remain in effect for one year or:
   ☐ Until Rockledge Regional Medical Center fulfills this request
   ☐ From the date of this authorization until the _____ day of _____ 20 _____
   ☐ Until the following even occurs: _____
   ☐ Other: _____

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

   Attention: Health Information Management
   110 Longwood Ave.
   Rockledge, FL 32955

10. Effect on Treatment: I understand that I may refuse to sign this Authorization for any use and that such refusal will not affect the commencement, continuation, or quality of my treatment at Rockledge Regional Medical Center.

11. 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 Rockledge Regional Medical Center.

12. Access: I understand that in certain circumstances Rockledge Regional Medical Center has the right to deny me access to all or portions of my Protected Health Information. Rockledge Regional 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 Rockledge Regional Medical Center to use and/or disclose my health information in the manner described above.

13. _____ _____
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:

14. _____ _____
Signature of Patient 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

_____ _____ _____
Date Time Name of Staff Releasing Records

PATIENT IDENTIFICATION

SCA.ROI

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ROC8400006 (01/20)