Authorization for Use or Disclosure of Protected Health Information

Patient Name	Date of Birth	Medical Record Number, if known
Address	City	State Zip
Telephone # ( )	Last 4 digits of SSN (Optional):	Check if patient is a: ☐ Shands employee ☐ University of Florida physician

By signing this form, I authorize the following:

Disclosure of protected health information **from** *(check one)*:	Disclosure of protected health information **to:**
☐ **Shands at University of Florida** ▪ P O Box 100345, Gainesville, FL 32610-0345 Phone: (352) 265-0131 ▪ Fax: (352) 265-1098 ☐ **Shands Rehab Hospital** ▪ 4101 NW 89th Boulevard, Gainesville, FL 32606 Phone: (352) 265-5491 ▪ Fax: (352) 265-5426 ☐ **Shands Vista** ▪ 4101 NW 89th Boulevard, Gainesville, FL 32606 Phone: (352) 265-5497 ▪ Fax: (352) 265-5426 ☐ **Shands HomeCare** ▪ 3515 NW 98th Street, Gainesville, FL 32606 Phone: (352) 265-0789 ▪ Fax: (352) 265-9276 ☐ **Radiology Dept., Shands at UF** ▪ PO Box 100374, Gainesville, FL 32610-0374 Phone: (352) 265-0107 ▪ Fax: (352) 265-6978	Person or Facility ☐ Check here if same as patient above Address ☐ Check here for records pick-up only City State Zip Phone: ( ) Attn:

Patient Information to be disclosed. *Check each category of information to be released.*

Specific Dates Needed:				
☐ History and Physical	☐ Operative Report(s)	☐ Discharge Summary	☐ Emergency Dept. Record	
☐ Problem List	☐ Medication Allergy List	☐ Medication List	☐ Lab/Pathology Report(s)	☐ Radiology Report
☐ Other diagnostic test results (describe):		☐ Other:		

Needed for doctor's appointment on (date):_____

Purpose of request: ☐ Treatment/continued care ☐ Payment/Billing ☐ Personal Use ☐ Other *(specify)*:_____

It may be possible to provide these records to you via secure Web site in PDF format, rather than paper copies. For this option, you must provide a valid and legible e-mail address below. You will receive an e-mail from HealthPort containing instructions for accessing the records. (Note: Electronic release is not available for Shands HomeCare records or radiological images at this time.)

E-mail address:

This authorization is for release of patient information including diagnosis, treatment, and/or examination related to mental health, substance and/or alcohol abuse, HIV/AIDS, and sexually transmissible diseases. By signing this authorization, I am giving permission for the uses and disclosures of patient information described above.

I understand that I have a right to inspect and to obtain a copy of any information disclosed. I hereby release and discharge Shands, all of its successors, and all persons acting under its permission and authority from any liability that may arise from the release of patient information as I have directed. I understand that state law prohibits the re-disclosure of the information disclosed to the persons/entities listed above without my further authorization, but that Shands cannot guarantee that the recipient(s) of the information will not re-disclose this information contrary to such prohibition.

I understand that this authorization will remain in effect for one (1) year or until I revoke it in writing. I understand that I have the right to revoke this authorization but only to the extent that Shands has not already relied on this authorization. I may revoke this authorization by providing a written statement to the Shands Department at the facility address or fax number checked above. If I refuse to consent, my refusal will not affect my enrollment in a health plan, eligibility for benefits, my eligibility to receive care or affect the quality of care I receive.

I understand that I may be charged a fee of up to $1.00 per page (plus applicable tax and handling) for every page copied. This fee is waived for copies provided to a health care provider for continuing medical treatment. I understand that this fee is within the limits allowable by Florida law. Additional fees may apply for radiological images.

Signature of patient / patient representative _____ **Date** _____

Complete following section only if the person making the request is NOT the patient.

Name of Requestor	Relationship to Patient ☐ Parent or Legal Guardian ☐ Other: _____

Shands HealthCare

RI0001

For Shands Use Only		ABS	DC	FS	PN
Dates of service:		AN	EC	HP	PO
		AU	EE	IM	PR
# pages	Date	CC	EK	LA	PS
Circle: Mail Fax Pickup E delivery		CH	EM	LD	PT/OT
Other:		CL	EN	OP	PX
		CO	ER	PF	XX
Checked ID? ☐ **Yes** ☐ **No initial** _____				Tech	

Date Posted4/27/12

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Distribution: Original- Patient record; Copy- Requestor

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