AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

Patient's Legal Name: ______________________ MRN: ______________

Address: ______________________ Date of Birth: ______________

______________________ Last 4 of SSN: ______________

Patient's Phone Number: ______________________

I authorize Lakeland Regional Health

Address: ______________ Phone: ______________ Fax: ______________

City: ______________ State: ______________ Zip Code: ______________

☐ to disclose my PHI to ☐ to obtain my PHI from

Name: ______________________ Fax: ______________

Address: ______________________ Phone: ______________

City: ______________ State: ______________ Zip: ______________

for the following dates of service: ______________________

☐ Paper ☐ Electronic ☐ Email address for electronic delivery: ______________________

The type of information to be used or disclosed is as follows (check appropriate boxes and include other information where indicated).

☐ Abstract (dictated reports, laboratory, cardiology, radiology)
☐ CD (radiology, echocardiogram or cath lab images)
☐ Emergency department record(s)
☐ History & physical
☐ Other ______________________

☐ Laboratory report(s)
☐ Operative report(s)
☐ Radiology report(s)
☐ Consultation report(s)
☐ Progress notes

☐ Pathology report(s)
☐ Billing record(s)
☐ Discharge summary
☐ EKGs

I understand that the protected health information specified above includes mental health, substance abuse (i.e., drugs, alcohol), HIV/AIDS status information unless redaction is requested. ☐ Redaction requested ______________ (please initial)

1. I understand that I may revoke this authorization at any time by notifying the Health Information Management department in writing. I understand that my revocation does not apply to information that has already been released in response to this authorization. I understand that 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.
2. I understand that the information disclosed may be subject to re-disclosure and no longer protected by federal or state privacy laws.
3. I understand that I am signing this form voluntarily and I am signing this under my own free will. Lakeland Regional Health will not condition my treatment, payment enrollment in health plans or my eligibility for benefits by signing this form.
4. I further agree to pay charges to provide the information requested per Florida Statute 395.3025 or Florida Administrative Code 64B8-10.003.
5. I understand that unless otherwise revoked, this authorization will remain valid for six (6) months from the date signed below.

Signature: ______________________ Date: ______________

Patient or Authorized Person: ☐ Patient ☐ Parent ☐ Legal Guardian ☐ Personal Representative ☐ Power of Attorney

☐ Photo ID verified

Witness: ______________________ Date: ______________

Released by: ______________________ Date: ______________ # of Pages Copied: ______________