CliniSanitas Medical Center

AUTHORIZATION FOR DISCLOSURE OF MEDICAL RECORDS

In accordance with the Health Insurance Portability and the Accountability Act of 1996 and the regulations promulgated thereunder governing the privacy of health information, and Florida law, the notice informs you of the purpose of the form and how it will be used.

PRINCIPAL PURPOSE(S): This form is to provide CliniSanitas with a means to request the use and/or disclosure of an individual's protected health information.

ROUTINE USE(S): To any third party or the individual upon authorization for the disclosure from the individual for: personal use; insurance; continued medical care; school; legal; retirement/separation; or other reasons.

DISCLOSURE: Voluntary. Failure to sign the authorization form will result in the non-release of the medical records.

Patient Name: _____ Home Telephone: ( ) _____

Home Address: _____

Date of Birth: ____/____/____ (mm dd yy) Social Security Number: _____

☐ I am the patient and hereby authorize the use or disclosure of health information, including protected health information, about me as described below.

☐ I am the patient's representative and understand and agree to the provisions of this authorization on behalf of the patient. My authority to act on behalf of the patient is as follows: _____

By signing this form, I authorize the release of health information, including protected health information as follows:

I authorize CliniSanitas to: ☐ disclose to ☐ obtain from _____

INFORMATION MAY BE DISCLOSED BY: CliniSanitas and any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, or other health care provider that has provided payment, treatment or services to me or on my behalf.

INFORMATION MAY BE DISCLOSED TO:

☐ Patient/Legally Authorized Representative ☐ CliniSanitas ☐ Health Plans and Third Party Payor(s)

☐ Any Pshysician, healthcare professional, hospital, clinic, laboratory, pharmacy, medical facility, or other health care provider that has provided payment, treatment or services to me or on my behalf.

☐ Other specify: _____

INFORMATION TO BE DISCLOSED:

☐ General Medical Record(s), including TB ☐ Progress Notes ☐ Consultations

☐ History and Physical Results ☐ Immunizations ☐ Family Planning ☐ Prenatal Records

☐ Diagnostic Test Reports (Specify Type of test)) _____

☐ Other: (specify) _____ Specify dates of service: _____

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By applying a check next to a category of highly confidential information listed below and signing on the appropriate line after the checked box, I specifically authorize the disclosure of the type of highly confidential information indicated next to my signature.

- ☐ HIV test results for non-treatment purposes _____
- ☐ Alcohol/Substance Abuse Service Provider Client Records _____
- ☐ Mental Health Records _____
- ☐ Psychologist/Psychotherapeutic Notes and Records _____
- ☐ Marriage/Family Therapist or Clinical Social Worker Records _____
- ☐ Child Abuse or Neglect/Early Intervention _____
- ☐ Sexual Assault _____
- ☐ Sexually Transmitted Disease _____

PURPOSE OF DISCLOSURE:

☐ Treatment ☐ Personal Use ☐ Billing/Payment ☐ Other (specify): _____

EXPIRATION DATE: This authorization will expire (insert date or event) _____ I understand that if I fail to specify an expiration date or event, this authorization will expire twelve (12) months from the date on which it was signed.

REDISCLOSURE: I understand that once the above information is disclosed, it may be redisclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

CONDITIONING: I understand that completing this authorization form is voluntary and that treatment, payment, enrollment, or eligibility for benefits cannot be conditioned on whether I sign this authorization.

REVOCATION: I understand that I have the right to revoke this authorization any time. If I revoke this authorization, I understand that I must do so in writing and that I must present my revocation to the medical record department. I understand that the revocation will 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, Medicaid and Medicare.

I request and authorize the disclosure of information described above.

_____ Date ____/____/____
Patient/Representative Signature mm dd yy

_____ _____
Printed Name Representative's Relationship to Patient

_____ Date ____/____/____
Witness (optional) mm dd yy

Patient Name: _____

ID#: _____

DOB: ____/____/____
mm dd yy