PARRISH
MEDICAL CENTER

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

1. I hereby authorize PARRISH MEDICAL CENTER, 951 North Washington Avenue, Titusville, FL 32796 to disclose the following information from the health records of: (FS 395.3025)

PATIENT NAME: _____ SOCIAL SECURITY NO. _____

DATE OF BIRTH: _____PHONE: _____

ADDRESS: _____

Covering the period(s) of health care:

FROM (date): _____ to (date): _____

2. Information to be disclosed:

☐ history and physical ☐ emergency room report ☐ discharge summary ☐ consultation reports
☐ progress notes ☐ physician orders ☐ operative reports ☐ EKG
☐ photographs, videotapes, digital or other images ☐ complete health record
☐ prenatal record ☐ anesthesia record
☐ X-rays: ☐ CT Scan ☐ MRI ☐ Ultrasound ☐ Mammography ☐ Nuclear Medicine ☐ Special Procedure
☐ Laboratory tests (please specify) _____ ☐ other (please specify) _____

If applicable, I also give permission for the following to be disclosed **(please initial):**

_____ acquired immunodeficiency syndrome (AIDS) or infection with human immunodeficiency virus (HIV)
_____ behavioral health services/psychiatric care
_____ treatment for alcohol and/or drug abuse

3. This information is to be released to (if yourself, please write "self") _____ for the purpose of (why do you need these records?)_____.

4. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Health Information Management 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 when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____. **If I fail to specify an expiration date, event, or condition, this authorization will expire in 90 days. If this authorization pertains to oneself as the patient, the expiration date can be documented as unlimited. If documented as such, it is the responsibility of the individual to notify the Health Information Services department of Parrish Medical Center of any life changes, i.e. guardianship, so that appropriate documentation is obtained for the noted change.**

5. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosures of my health information, I can contact the privacy officer at Extension 7101.

6. The facility, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein

Signed: _____
(Patient) (Date)

_____
or (Legal Representative) (Relationship to Patient) (Date)

_____
(Signature of Witness) (Relationship to Patient) (Date)

Patient ID: _____