Tampa | HSC HIM Shared Services Center

Tampa HCA Shared Service Center – HSC Release of Information
Attn: HealthPort
3301 Executive Way
Miramar, FL 33025
1-866-463-7439

Please return to fax # 1-855-815-3577

Section A: This section must be completed for all authorizations

Patient Name:	Birth Date:	Last Four Digits of SS No. (**optional**):

Provider's Name:	Recipient's Name:	Phone:
Provider's Address:	Address 1:	
	Address 2:	
	City: / State: / Zip:	

Request Delivery (If left blank, a paper copy will be provided): ☐ Paper Copy ☐ Email ☐ Electronic Media, if available (*e.g.*, USB drive, CD/DVD, email). NOTE: In the event the facility is unable to accommodate an electronic delivery request, an alternate delivery method will be provided (*e.g.,* paper copy).

Email Address (If email checked above. Please print legibly):

This authorization will expire on the following: (Fill in the date or the event but not both.).
If there is no date of expiration for this authorization as listed below, the authorization will expire 30 days from the date signed.
Date: **Event:**

Purpose of disclosure:

Hospital to release records from:

- ☐ Aventura Hospital and Medical Center
- ☐ Kendall Regional Medical Center
- ☐ Mercy Hospital
- ☐ Northwest Medical Center
- ☐ Plantation General Hospital
- ☐ Sister Emmanuel
- ☐ University Hospital and Medical Center
- ☐ Westside Regional Medical Center

Description of information to be used or disclosed

Is this request for psychotherapy notes?
☐ Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below.
☐ No, then you may check as many items below as you need.

Check what is needed:

Description:	*Date(s):*	*Description:*	*Date(s):*	*Description:*	*Date(s):*
☐ All PHI in medical record		☐ Operative information		☐ Labor/delivery sum.	
☐ Admission form		☐ Cath lab		☐ OB nursing assess	
☐ Dictation reports		☐ Special test/therapy		☐ Postpartum flow sheet	
☐ Physician orders		☐ Rhythm strips		☐ Itemized bill:	
☐ Intake/outtake		☐ Nursing information		☐ UB-92	
☐ Clinical Test		☐ Transfer forms		☐ Other:	
☐ Medication sheets		☐ ER information		☐ Other:	

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, genetic information, psychiatric, HIV testing, HIV results or AIDS information. _____ (Initial)

I understand that:

1. I may refuse to sign this authorization and that it is strictly voluntary.
2. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be re-disclosed.
5. I understand that I may see and obtain a copy the information described on this form, for a reasonable copy fee, if I ask for it.
6. I get a copy of this form after I sign it.

Section B: Is the request of PHI for the purpose of marketing and/or does it involve the sale of PHI? ☐ Yes ☐ No
If yes, the health plan or health care provider must complete Section B, otherwise skip to Section C.

Will the recipient receive financial or compensation in exchange for using or disclosing this information? ☐ Yes ☐ No
If yes, describe:
May the recipient of the PHI further exchange the information for financial remuneration? ☐ Yes ☐ No

Section C: Signatures

I have read the above and authorized the disclosure of the protected health information as stated.

Signature of Patient/Patient's Representative:	**Date:**
Print Name of Patient's Representative:	**Relationship to Patient:**

ID verified by: _____ (Initials)

Authorization for Release of PHI

Patient Label

HCA Shared Services Center
31975 US Highway 19 North
Palm Harbor, FL 34684

contracts with HealthPort to process requests for copies of medical records. The release of patient medical information is governed under Federal and Florida state statutes.

The following must be presented:

A completed authorization (all sections of the authorization must be completed for records to be released.)

What we will provide at no cost to you:

Records sent directly to your physician for continuing care. Pertinent information (an abstract) for continuing care includes transcribed reports (discharge summary, history and physical, operative reports), radiology reports, lab reports and clinic notes (if applicable). If you would like additional records sent, please specify on the authorization what records are to be sent.

Requests for records to be sent to a third party (attorney, insurance company) can only be completed with a request and authorization directly from that party. If you desire records for this purpose or for your own personal use, the records **will be mailed to you and the following fees will apply**. If you believe the records you are requesting may exceed a certain dollar amount and would like to be notified of this in advance, please indicate in the area below.

$ 0.25 per page
+ applicable tax and postage cost

Please notify me if the cost of my records exceeds $_____.

By my signature below, I acknowledge that I am aware of the fee for copies of medical records. I agree to pay this fee when I receive an invoice from ***HealthPort.***

PLEASE PRINT:

NAME:_____ PHONE #: (___) _____

ADDRESS:_____
Street City State Zip

SIGNATURE:_____ DATE:_____

Patient Label