

Medical Record Number \_\_\_\_\_

Facility \_\_\_\_\_

Please initial appropriate classification of information when applicable:

\_\_\_\_ Drug & Alcohol Treatment Information and/or records

\_\_\_\_ Mental Health Information and/or records

\_\_\_\_ HIV/AIDS Information and/or records

I understand that, under Florida Law, the classification of records checked above relating to treatment rendered to me are privileged and confidential and cannot be released to me or those designated by me or my legal guardian without an expressed and informed consent. In addition, I understand that those records will not be released to persons and agencies other than those designated by me or my personal representative or otherwise provided in Florida law.

Patient Name: \_\_\_\_\_ / \_\_\_\_\_  
Last First Middle Initial Maiden

Address: \_\_\_\_\_  
Street City State Zip Code

Birth Date : \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Telephone : \_\_\_\_\_ Social Security Number: \_\_\_\_\_

I, \_\_\_\_\_, authorize \_\_\_\_\_ to release my health  
Patient/Personal Representative Name (please circle one) Name of Facility

information indicated below to the following party: (check one)

\_\_\_\_ MYSELF  
\_\_\_\_ OTHER

Name Address City State Zip

For the purpose of: \_\_\_\_\_

I authorize release of information covering treatment dates of: \_\_\_\_\_

The type and amount of information to be disclosed is as follows: (include dates where appropriate):

- \_\_\_\_ Entire Medical Record, excluding: \_\_\_\_\_
- \_\_\_\_ History and Physical \_\_\_\_\_
- \_\_\_\_ Consultations \_\_\_\_\_
- \_\_\_\_ Discharge Summary \_\_\_\_\_
- \_\_\_\_ Operative Report \_\_\_\_\_
- \_\_\_\_ Pathology Report \_\_\_\_\_
- \_\_\_\_ Physician Progress Notes \_\_\_\_\_
- \_\_\_\_ Physician's Orders \_\_\_\_\_
- \_\_\_\_ Physical Therapy Records \_\_\_\_\_
- \_\_\_\_ Nurses Notes \_\_\_\_\_
- \_\_\_\_ Laboratory Reports : from \_\_\_\_\_ (date) to \_\_\_\_\_ (date)
- \_\_\_\_ Radiology Reports : from \_\_\_\_\_ (date) to \_\_\_\_\_ (date)
- \_\_\_\_ Problem List \_\_\_\_\_
- \_\_\_\_ Photos, (Circle purpose): Media PR Other \_\_\_\_\_
- \_\_\_\_ Media Interview \_\_\_\_\_
- \_\_\_\_ Other, describe \_\_\_\_\_

- I understand that I have the right to withdraw my authorization at any time except to the extent that action has already been taken pursuant to this authorization. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Medical Records Department.
- I understand that authorizing the disclosure of this health information is voluntary, I can refuse to sign, and the facilities of Broward Health will not base my treatment, payment or eligibility for benefits on whether or not I provide authorization for the requested use or disclosure. I understand that the recipient may be prohibited from disclosing substance abuse information. I understand that I may inspect or copy the information to be disclosed, as provided in CFR 164.524 (with a reasonable charge).
- I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient of the information and is no longer protected by federal confidentiality laws or Broward Health.
- I understand that Broward Health will release only the minimum amount of information necessary to fulfill a request.

**Unless otherwise revoked, this authorization will expire six months from the date of the signature listed below.**

\_\_\_\_\_  
Patient/Personal Representative Signature Print Name \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Date

\_\_\_\_\_  
Broward Health Authorized Signature Print Name \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Date

\_\_\_\_\_  
Witness Print Name \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Date

ADDRESSOGRAPH



**AUTHORIZATION FOR RELEASE OF CONFIDENTIAL MEDICAL INFORMATION**

WHITE - MEDICAL RECORD CANARY - PATIENTS