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**	____ **Genetic 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 : _____

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

____I will pick up copies of my records, Please provide my records in ____Paper Form ____Encrypted CD

____Mail copies of my records to the individual listed above via US mail. Please provide my records in ____Paper Form ____Encrypted CD

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

ROI CONSENT

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BROWARD HEALTH®

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL MEDICAL INFORMATION

WHITE - MEDICAL RECORD CANARY - PATIENTS

ADDRESSOGRAPH