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** _____ **Sexually Transmitted Diseases (STD's)** _____ **Pregnancy**

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 _____CD
_____Mail copies of my records to the individual listed above via US mail. Please provide my records in _____Paper Form _____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
_____ Psychotherapy Notes
_____ 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