ORLANDO HEALTH
1414 Kuhl Ave.
Orlando, FL 32806

LINE UP PATIENT I.D. LABEL HERE

AUTHORIZATION TO OBTAIN, RELEASE OR REVIEW PROTECTED HEALTH INFORMATION

Patient Name:_____ Social Security # (last 4 digits): _____

Address:_____

Date of Birth: ____/____/____ Date of Service:_____ Phone #:_____

Identification Shown:_____ Mail ❑ Secure Email ❑ / Pick Up: Paper ❑ CD ❑

Email Address _____

I hereby authorize Orlando Health to use and **disclose to:** ❑ **or obtain from:** ❑ **or allow review:** ❑

_____ _____
Name of Facility or Person Phone

_____
Street Address City State Zip Code

SEND RECORDS TO: (Name of Facility or Person)_____

_____
Street Address City State Zip Code

the following information contained in my medical record regarding my hospitalization, care and treatment (please initial):

____ Complete Record ____ All Diagnostic Test Results ____ Pathology Report(s)
____ Abstract of Record ____ Consultation ____ Lab Only
____ Therapy Records ____ Radiology Only ____ Other (please specify)
____ Progress Note(s) ____ Operative Report _____

The purpose for the release of information at the request of the individual is:
❑ Insurance ❑ Legal Action ❑ Continued Treatment ❑ Personal Use ❑ Patient Communication (Behavioral Health)
❑ Other (Please Specify) _____
❑ Family and Medical Leave Act/Disability Forms
This authorization will expire on the following date, event or condition: _____
I understand that this authorization extends to all or any part of the records designated above, which may include psychiatric information, and/or genetic counseling/testing, and/or alcohol/drug abuse and/or AIDS (Acquired Immunodeficiency Syndrome), and/or may include the result of an HIV test or the fact that an HIV test was performed. I expressly consent to the release of information as designated above unless initialed below or otherwise required by law.

May **NOT** include information related to (please initial):

____ HIV/AIDS ____ Mental Health ____ Drug and/or Alcohol Abuse ____ Genetic Counseling/Testing Information

If I fail to specify an expiration event or condition, the authorization will expire in one year. I understand that this authorization is revocable upon written notice to the office where the original authorization is retained, except to the extent that action has already been taken on this authorization. I understand that my protected health information that is used or disclosed under this authorization may be subject to re-disclosure by the recipient and the privacy of my protected health information may no longer be protected by law. I further understand that Orlando Health may not condition the provision of treatment, payment, enrollment in the health plan, or eligibility for benefits on the provision of this authorization. I understand that I will receive a signed copy of this form.

_____ _____
Patient/Legal Representative or Parent/Legal Guardian Signature Date Time

Official Use Only: _____ Date:_____

❑ Name of Person Releasing Information ❑ Name of Person Assisting with Review Number of pages copied _____

❑ **I wish to revoke this authorization.** Signature: _____ Date: _____

INTERPRETER ONLY

(Please Print)

Name: _____ Agency: _____

Telephone:_____ Language: _____