Patient Name: _____ Date of Birth: _____ MR#: _____
Address: _____ Phone #: _____
City: _____ State: _____ Zip Code: _____

To be completed by requester: ☐ Pick Up ☐ Mail ☐ Other: _____ ☐ E-Mail: _____
If requested health information is needed for a doctor's appointment, please specify date: _____

THE FOLLOWING INDIVIDUAL OR ORGANIZATION IS AUTHORIZED TO RELEASE THE FOLLOWING:

Name: AdventHealth Palm Coast Phone: _____
Address: 60 Memorial Medical Parkway Fax: _____
City: Palm Coast State: FL Zip Code: 32164

Admission/Discharge Date(s): _____
Forward to Health Information Management (Medical Records) for:
☐ *Abstract ☐ Discharge Summary ☐ Operative Report ☐ Emergency Room Report ☐ EKG
☐ Pathology Report ☐ History & Physical ☐ Laboratory Report ☐ Imaging Report
☐ Consultation ☐ Other (specify) _____
Forward to Patient Business Office for: ☐ Billing Information
Forward to Cardiology Dept. for: ☐ Cath Lab Images
Forward to Radiology Dept. for: ☐ Imaging Exams (specify) _____

Reason for requesting information: _____
Requests may be subject to copying fee

THIS INFORMATION MAY BE RELEASED TO AND USED BY THE FOLLOWING INDIVIDUAL OR ORGANIZATION:

Name: _____ Phone: _____
Address: _____ Fax: _____
City: _____ State: _____ Zip Code: _____
Physician E-Mail: _____ Patient E-Mail: _____

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Health Information Management Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. **Unless otherwise revoked, this authorization will expire on the following date, event or condition (not to exceed 90 days): _____. If I fail to specify an expiration date, event or condition, this authorization will expire 90 days from the date signed.**

I understand that authorizing the release of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or obtain a copy of the information to be used or released, as provided in CFR 164.524. I understand that any release of information carries with it the potential for an unauthorized re-release and the information may not be protected by Federal confidentiality rules. If I have questions about release of my health information, I can contact the authorized individual or organization making disclosure.

I understand the information in my health record may include psychiatric, alcohol or drug abuse/testing information which may be protected by Federal and State Regulations. I also understand that my health record may include information relating to AIDS, HIV, and/or sexually transmitted disease, and all other sensitive information.

Patient Signature: _____ Date: _____

Authorized Representative/Parent: _____ Date: _____
Printed Name of Authorized Representative/Parent: _____
Relationship to Patient: _____
Address and Phone # of Authorized Representative/Parent: _____

*Abstract consists of facesheet, discharge summary, history & physical, consults, operative notes, emergency record, lab, imaging, EKG reports, and pathology. (if available).

AUTHORIZATION FOR USE AND/OR DISCLOSURE AND REQUEST FOR ACCESS TO PROTECTED HEALTH INFORMATION

PATIENT PLATE

East Florida Region
rev. 04/16
#rg00005

IHRLSINFO