HEREBY REQUEST AND AUTHORIZE:

☐ Florida Hospital Zephyrhills ☐ _____

TO RELEASE THE HEALTH RECORDS SPECIFIED BELOW:

Date(s) of service: _____

_____ _____

(patient name) (date of birth)

☐ ALL GENERAL MEDICAL RECORDS - OR - ☐ LIMITED RECORDS (SPECIFY): _____

☐ INCLUDING HIV / AIDS RECORDS (IF APPLICABLE)

☐ INCLUDING PSYCHIATRIC / PSYCHOLOGICAL RECORDS (IF APPLICABLE)

FOR THE PURPOSE OF:

☐ continuing to receive medical care

☐ information for insurance company

☐ information for attorney

☐ personal use ☐ other (specify): _____

☐ other (specify): _____

THESE RECORDS ARE TO BE PROVIDED TO:

_____

(name of person or agency information is being disclosed to)

_____

(address)

_____

(city) (state) (zip) (telephone / FAX number)

AUTHORIZED BY:

_____ _____

(date signed) (signature of patient authorized representative*)

Authorized representative

☐ Parent

☐ Surviving Spouse

☐ *Legal Guardian

☐ Administrator / Executor of State

☐ Other (specify): _____

* - if legal guardian, administrator or executor of estate, legal proof of this status must accompany this authorization.

The patient or authorized representative may revoke this authorization at any time after it is signed by submitting a written request to the facility. This authorization will expire automatically 60 days after the date signed.

NOTE TO THE RECIPIENT OF THE ATTACHED RECORDS:

PROHIBITION ON REDISCLOSURE

This information has been disclosed to you from records whose confidentiality is protected by state law. State law prohibits you from making any further disclosure of such information without the consent of the person to whom such information pertains, or as otherwise permitted by state law. With regard to HIV / AIDS records, specific, written consent is required. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

A COPY OF THIS DOCUMENT ACCOMPANIES THE RECORDS DISCLOSED

FLORIDA HOSPITAL
Zephyrhills
7050 Gall Boulevard
Zephyrhills, FL 33541-1399
FAX: (813) 783-6195

AUTHORIZATION FOR RELEASE OF PATIENT MEDICAL INFORMATION

Form 909462 Rev 11/99

IHRLSINFO

Patient ID Label