Sacred Heart Health System

Authorization for Release of Medical Information From Sacred Heart Health System (page 1 of 2)

Patient's Name: _____ (Last) _____ (First) _____ (Middle)

Address: _____ _____ (City) _____ (State) _____ (Zip)

Date of Birth: _____ Social Security No.: _____ Telephone Number: _____

I hereby authorize and request SACRED HEART HEALTH SYSTEM (Releasor) to release a copy of the following medical records to:

☐ Patient Named Above

_____
Name (Releasee)

_____
Address

_____
City State Zip Telephone

REQUIRED

The purpose of the request for the Medical Records is:

☐ **At the request of the patient.**

☐ **Other. Explain:** _____

_____

NOTE: If you fail to specify which records you desire, you will only receive a copy of the discharge summary. A copy of the medical records ("Protected Health Information") of the above named patient pertaining to: (Check appropriate box and list the date)

☐ SACRED HEART HOSPITAL OF PENSACOLA
☐ SACRED HEART HOSPITAL ON THE EMERALD COAST
☐ SACRED HEART HOSPITAL ON THE GULF
☐ Emergency Care, Date: _____
☐ Hospitalization, Date: _____ to _____
☐ Outpatient Care, Date: _____
☐ Sacred Heart Home Care, Date: _____
☐ Sacred Heart Medical Group, Dates: _____
Physician: _____
☐ Pediatric Care Center, Dates: _____
☐ Seton Center; Dates: _____
☐ Other: _____

SPECIFIC REPORTS REQUESTED:

☐ History & Physical
☐ Physical Therapy Notes
☐ Discharge Summary
☐ Abstract (H&P, discharge summary, consult, OP report)
☐ Lab
☐ Occupational Therapy Notes
☐ X-Ray
☐ Operative Report
☐ Pathology
☐ Other: _____

REQUIRED:

____ **I do** ____ **I do not** authorize the release of information, including, if applicable, specific laboratory tests of HIV Infection (Human Immunodeficiency Virus, the causative agent of AIDS) or the diagnosis of Acquired Immune Deficiency Syndrome (AIDS) or AIDS related conditions, all medical records or other information regarding my treatment, hospitalization including psychological or psychiatric impairment, drug abuse and/or alcoholism or sickle cell anemia.

Releasor, its agents and employees, are hereby authorized to obtain, inspect, and reproduce such records and/or information and are hereby relieved of any responsibility or liability that may arise from the release or reproduction of such records and/or information in accordance with this Authorization.

This Authorization will expire one (1) year from the date of my signature.

I understand that I have the right to revoke this Authorization, if the revocation is in writing except if (i) Sacred Heart has taken action in reliance upon this Authorization, or (ii) if this Authorization was given as a condition of obtaining insurance coverage, other law provides that the insurance company has the right to contest a claim under the insurance policy.

I understand that I may revoke this Authorization by providing a written revocation to the Director of Health Information, or if applicable, Manager of Health Information, Sacred Heart Hospital, 5151 North Ninth Avenue, Pensacola, Florida 32504, Sacred Heart Hospital on the Emerald Coast, 7800 Highway 98 West, Destin, Florida 32550, Sacred Heart Hospital on the Gulf, 3801 East Hwy. 98, Port St. Joe, Florida 32456.

I understand that my Protected Health Information that is used or disclosed under this Authorization may be subject to redisclosure by the recipient, and the privacy of my Protected Health Information may no longer be protected by law.

_____ _____
Signature of Patient Date

_____ _____
Authorized Representative if Patient unable to sign Date

_____ _____
Description of Authorized Representative's Authority to Sign for Patient Witness

PC > Consents & Legal > Information Release
EC and GC > Consents & Legal > General Consents

ROI

Sacred Heart Health System

Authorization for Release of Medical Information From Sacred Heart Health System (page 2 of 2)

It is our desire to provide you with quality customer service in a timely manner.

Sacred Heart Health System policy and mission is to protect patients' rights and to limit Protected Healthcare Information on a need to know basis. By law, we must have the signature of the patient or the patient's authorized representative on an Authorization to release Protected Healthcare Information.

For your convenience, the fee schedule for copies of medical records is listed below:

Florida Statute 395.3025

Hard Copy per page:	**$1.00**
Hard Copy -Clinical Facilities:	**$1.00 per page, for first 25 pages,.25¢ for each additonal page** (ex.: Home Care, MSO, etc.)
Microfiche per page:	**$1.00**
Year Search fee (excluding patient requests):	**$1.00 per year up to $15.00 maximum**
Shipping and Handling:	**Actual cost**
Taxes:	**Actual cost**

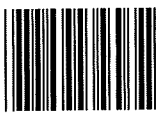
In our efforts to provide you with the information requested, we hope that we have met your expectations.

Signature of Patient _____ Date _____

Authorized Representative if Patient unable to sign _____ Date _____

Description of Authorized Representative's Authority to Sign for Patient _____ Witness _____

PC > Consents & Legal > Information Release
EC and GC > Consents & Legal > General Consents



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