Authorization For Release Of Protected Health Information

I, ____, date of birth ___/___/______, hereby request and authorize

❑ **Florida Hospital Physician Group, Inc.**

____

____

❑ Other____
(Name and address of provider releasing the records)

To release my PHI (Protected Health Information) specified: ❑ All medical records, or

❑ Limited records (specify by type of record or by date of service): ____

❑ Billing Records: ____

For the purpose of:

❑ Continuing to receive medical care

❑ Information for insurance company

❑ Information for attorney

❑ Personal use, by and at the request of the patient or his/her legal representative

❑ Other (specify) ____

These records may be provided to:

Name of person or agency information is authorized to be disclosed to ____

Address ____

City ________________________ State _________ Zip ____________ Telephone/Fax Number _____________________

Authorized By:

Date signed _________________ Signature of patient or legal representative*___________________________________

*If you are signing as the patient's representative, please print your name____, and describe why you have the legal authority to represent the patient (for example: spouse, child, durable power of attorney for healthcare, etc.):
____

Expiration Date of this Authorization____________________

***Note:** If your authority to act as the patient's representative comes from a document (for example: a durable power of attorney for healthcare, appointment of healthcare surrogate, appropriate estate documents or a custody decree), a copy of the document must accompany this authorization.

You may revoke this authorization at any time by notifying the Florida Hospital Physician Group, Inc., in writing to the address printed at the top of this form, of your intent to revoke this authorization. The written revocation will not affect any information already used or disclosed by the physician practice prior to revocation. You will not be denied services based on your refusal to sign this authorization. Once out of the Florida Hospital Physician Group's possession, the information released based on this authorization may no longer be protected and the Florida Hospital Physician Group, Inc. will not be responsible for its re-disclosure.

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 and federal laws. Unless this is your health information, state and federal laws prohibit you from making any further disclosure of such information without the authorization of the person to whom such information pertains, or as otherwise permitted by law. A general authorization for the release of medical or other information may not be sufficient for the re-release of this information.

A COPY OF THIS DOCUMENT ACCOMPANIES THE RECORDS DISCLOSED
(Original: Medical Records, Practice Office named above Copy: Patient / Recipient of Records)

The following fee(s) will be assessed:
$1.00 per page for paper records for the first 25 pages and .25 for each page in excess of 25 pages; and/or
A $2.00 charge for non-paper records, plus any applicable postage, as requested by the patient.