

WOMEN'S PHYSICIANS OF JACKSONVILLE

Authorization To Disclose Protected Health Information

PLEASE PRINT

RELEASE INFORMATION FROM: _____ _____ _____ _____ _____	SEND INFORMATION TO: _____ _____ _____ _____ _____
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PURPOSE OF DISCLOSURE: Continued Care Personal Other: _____

INFORMATION TO BE DISCLOSED: _____

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Emergency Report | <input type="checkbox"/> Laboratory Result(s) | <input type="checkbox"/> Abstract* |
| <input type="checkbox"/> History and Physical | <input type="checkbox"/> Consultation Report | <input type="checkbox"/> Radiology Report(s) | <input type="checkbox"/> Entire medical record |
| <input type="checkbox"/> Operative/Procedure Report | <input type="checkbox"/> Pathology Report(s) | <input type="checkbox"/> EKG Results | <input type="checkbox"/> Echo Tapes |
| <input type="checkbox"/> Psychiatry/Psychology
Documentation | <input type="checkbox"/> Billing statement | <input type="checkbox"/> Pathology Materials | <input type="checkbox"/> Cath CDs |
| <input type="checkbox"/> Medication List | | <input type="checkbox"/> Other _____ | |

* Abstract includes, as applicable: At SLH - Discharge Summary, History and Physical, Operative/Procedure Report(s), Consultation Report(s), and test result(s); At MCJ - Most Recent Return Visit, History and Physical, Consultation and Test Result(s).

IDENTIFYING INFORMATION AT THE TIME OF SERVICE:

_____ <i>Patient's Full Name</i>	_____ <i>Patient's Social Security Number</i>
_____ <i>Address</i>	_____ <i>Patient's Date of Birth</i>
_____ <i>City/State/Zip</i>	_____ <i>Patient's Phone Number</i>

I understand that disclosure of the information in this medical record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information relating to behavioral or mental health services or treatment, treatment for substance abuse, or genetic test results.

I understand that this authorization will expire in one year from the date signed below unless otherwise specified: _____

I understand that I may be charged for copies of this information in accordance with Florida law.

I understand that once the information is disclosed, the information is subject to redisclosure and may no longer be protected by the federal privacy regulations. This form may be revoked at any time providing the information has not already been disclosed. I may revoke this authorization by written notification.

I understand the matters discussed on this form. I release the provider, its employees, officers and directors, medical staff members, and business associates from any legal responsibility or liability for the disclosure of the above information to the extent indicated and authorized herein.

*Signature of Patient or Patient's Representative** _____
Relationship (if not patient) _____
Date

*If a personal representative of the patient signs the authorization, please indicate his or her authority to act.

IF MORE THAN 10 PAGES, PLEASE MAIL!