Authorization to Use or Disclose Protected Health Information

☐ Morton Plant Hospital ☐ Mease Countryside Hospital

☐ Mease Dunedin Hospital ☐ Morton Plant North Bay Hospital

I hereby authorize the above hospital(s) to use or disclose the following information from the health records of the individual whose name is described below.

Please print:

Patient Name:_____ Date of Birth: _____

Address:_____
(city) (state) (Zip)

Phone Number_____ Social Security #_____

I authorize the above hospital(s) to release medical, mental, alcohol and/or drug abuse, HIV (human immunodeficiency virus) testing, AIDS, eating disorders or any other medical information of a sensitive nature to the following individuals or organization(s):

Name:_____

Address:_____
(city) (state) (Zip)

- This information for which I'm authorizing disclosure will be used for the following purpose:

Description:_____

Dates of service to be released:_____

The type of information to be used or disclosed is as follows (check the appropriate boxes and include other information where indicated)

- ☐ Abstract
- ☐ Discharge Summary
- ☐ History and Physical reports
- ☐ Operative Reports
- ☐ Consultation Reports
- ☐ Progress Notes
- ☐ Lab results/X-Ray and imaging
- ☐ Emergency Room Records
- ☐ Other: (please describe)

_____

I understand that if the organization authorized to receive the information is not a health plan or healthcare provider, the released information may no longer be protected by Federal privacy regulations. I understand that I need not sign this authorization to ensure treatment. This authorization shall remain valid for six months from the date signed below.

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 department or facility listed on the authorization. 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.

Signed _____ Date _____

Patient or Authorized Person, Parent ( ) Legal Guardian ( ) Executor ( ) Power of Attorney ( )

☐ Photo ID checked

Witness

_____Date_____

Copied by:_____Date:_____Pages copied:_____

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