ORLANDO REGIONAL HEALTHCARE

1414 Kuhl Avenue • Orlando, Florida 32806-2093

PATIENT IDENTIFICATION

AUTHORIZATION TO OBTAIN, RELEASE OR REVIEW PROTECTED HEALTH INFORMATION

I, ________________________________ hereby authorize Orlando Regional Healthcare to:
Patient/Legal representative

☐ **Allow review** (open and closed records)
☐ **Release copies** of Protected Health Information of ________________________________
☐ **Obtain records** Patient

From: Name of individual, healthcare facility or agency

____

____
Address City State Zip Code

Send records to:

____
Fax Number

____
Address City State Zip Code

For the purpose of: ☐ Continued Treatment ☐ Personal Use
☐ Patient Communication (Behavioral Health) ☐ Other (please specify)________________

Date(s) of Service: **From:** ________________________ **To:** ________________________

This authorization will expire on the following date, event or condition: ________________________.
If I fail to specify an expiration event or condition, the authorization will expire in one year. I understand that this authorization is revocable upon written notice to the office where the original authorization is retained, except to the extent that action has already been taken on this authorization. Mental health, alcohol, drug, HIV and/or AIDS information is confidentially protected by Federal and state law which prohibits disclosure without specific written authorization of the undersigned, or as otherwise permitted by such regulations. I further request that no genetic counseling/testing information in my record be released without my written authorization, except as otherwise required by law. I understand that **I may select the information from the list below to be released by placing my initials in the space provided. The potential for information disclosed pursuant to the authorization to be subject to redisclosure by the recipient and no longer be protected by this rule.** I further understand that Orlando Regional Healthcare may not condition the provision of treatment, payment, enrollment in the health plan, or eligibility for benefits on the provision of this authorization.

Place your initials by each item to be released or reviewed:

_____ Complete Record
or
_____ Abstract of Record

_____ All diagnostic test results
_____ Therapy Records
_____ Consultation/Progress Note(s)
_____ Radiology only

_____ Pathology/Operative Report(s)
_____ Lab only
_____ Other (please specify) ________________

In addition, place your initials by each specific item: (if applicable)

_____ Mental Health _____ HIV Testing _____ Genetic Counseling/Testing Information _____ Drug and/or Alcohol _____ AIDS Information

________________________________ ________________
Patient /Legal Representative or Parent/Legal Guardian Signature Date of Authorization

________________ ________________ ________________
Patient's Date of Birth Patient's Social Security Number Identification Shown

____
Address City State Zip Code

________________________________ ________________________________
Telephone Number Translator or Interpreter's Name

☐ **I wish to revoke this authorization**

Patient Signature:________________________________ Date:____________

Official Use Only: ________________________________ **Date:**____________
☐ **Name of Person Releasing Information** ☐ **Name of Person Assisting with Review**
Number of pages copied ________