

Please return to fax # 1-877-611-9982

<b>Section A: This section must be completed for all Authorizations</b>					
<b>Patient Name:</b>		<b>Birth Date:</b>		<b>Social Security No. (optional):</b>	
<b>Recipient's Name:</b>					
<b>Address 1:</b>					
<b>Address 2:</b>					
<b>City:</b>		<b>State:</b>		<b>Zip:</b>	
This authorization will expire on the following: (Fill in the Date or the Event but not both.)					
<b>Date:</b>			<b>Event:</b>		
<b>Purpose of disclosure:</b>					
<b>Description of information to be used or disclosed</b>					
Is this request for psychotherapy notes?					
<input type="checkbox"/> Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. <input type="checkbox"/> No, then you may check as many items below as you need.					
Hospital to release records from:					
<input type="checkbox"/> Blake Medical Center <input type="checkbox"/> Brandon Regional Hospital <input type="checkbox"/> Medical Center of Trinity <input type="checkbox"/> Medical Center of Trinity West Pasco <input type="checkbox"/> Doctors Hospital of Sarasota <input type="checkbox"/> Edward White Hospital		<input type="checkbox"/> Englewood Community Hospital <input type="checkbox"/> Fawcett Memorial Hospital <input type="checkbox"/> Largo Medical Center <input type="checkbox"/> Largo Medical Center - Indian Rocks Campus		<input type="checkbox"/> Northside Hospital <input type="checkbox"/> Oak Hill Hospital <input type="checkbox"/> Regional Med Center of Bayonet Point <input type="checkbox"/> South Bay Hospital <input type="checkbox"/> St. Petersburg General Hospital	
<i>Description:</i>	<i>Date(s):</i>	<i>Description:</i>	<i>Date(s):</i>	<i>Description:</i>	<i>Date(s):</i>
<input type="checkbox"/> Entire medical record <input type="checkbox"/> Abstract ( <i>most common</i> ) <input type="checkbox"/> Physician Orders <input type="checkbox"/> Physician Progress Notes <input type="checkbox"/> Physician Dictated Reports		<input type="checkbox"/> Clinical Test <input type="checkbox"/> Medication Sheets <input type="checkbox"/> ED Information <input type="checkbox"/> Admission Form <input type="checkbox"/> Operative Documentation		<b><u>Super-Confidential Information</u></b> <input type="checkbox"/> HIV Testing <input type="checkbox"/> HIV & AIDS Documentation <input type="checkbox"/> Psychiatric Documentation <input type="checkbox"/> Alcohol & Drug Abuse Documentation	
I understand that:					
1. I may refuse to sign this authorization and that it is strictly voluntary. 2. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization. 3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices. 4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be re-disclosed. 5. I understand that I may see and obtain a copy the information described on this form, for a reasonable copy fee, if I ask for it. 6. I get a copy of this form after I sign it.					
<b>Section B: Signatures</b>					
I acknowledge, and hereby consent to such, that the protected health information released may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. I also acknowledge that I have read the above and authorize the disclosure of the protected health information as stated.					
<b>Signature of Patient/Patient's Representative:</b>				<b>Date:</b>	
<b>Print Name of Patient's Representative:</b>				<b>Relationship to Patient:</b>	



PATIENT LABEL