THIS FORM SHOULD ONLY BE USED WHEN REQUESTING PATIENT HEALTH INFORMATION FROM OUTSIDE HEALTHCARE PROVIDERS.

AUTHORIZATION FOR THE REQUEST OF PATIENT HEALTH INFORMATION FROM OUTSIDE HEALTH CARE PROVIDERS

Please Print Clearly

Patient Name: _____ Date: _____

Date of Birth: _____ Social Security Number: _____

Dates of Service: From _____ Through _____

I, _____, **hereby request and authorize the release of the following records from:** _____

(Facility/Physician PHI requested from) **Phone Number**

_____

Street/PO Box **City** **State** **Zip Code**

____ **Hospital Abstract**	____ **OP Report**	____**Consultation**
____ **Labs**	____ **Discharge Summary**	____**Pathology**
____ **X-Ray Reports**	____**Cardiac Cath**	____**Cardiology**
____**X-Ray Films**	____**EKG's**	____**Doctor Office Visit Notes**

Other: _____

This release of information is for continuity of care, unless otherwise noted: _____

My Records may contain the following and, **unless crossed out and initialed**, I specifically authorize their release:

HIV Test Results (Test for AIDS) **AIDS Related Records** **Drug or Alcohol Records**

TO: Martin Memorial Health Systems: _____
Full Name/Location of Recipient of Your Records

_____
Street/PO Box

_____
City State Zip Code

_____
Telephone Number Fax Number EMail Address

Patient or Authorized Signature: _____ **Date:** _____

Relationship to Patient: _____
Explain and/or attach Legal Documentation

Pursuant to Florida law and the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule, the record may be given only to the person designated, and it may be used only for the purpose listed on this form. Charges are in compliance with Florida law. I understand that once my information is disclosed to the recipient above, it may be redisclosed to individuals not subject to HIPAA and may no longer be protected by HIPAA. I understand that signing this authorization is voluntary and will not affect my receipt of treatment. I understand that I may revoke this authorization at any time, in writing, to the address listed above provided that the information has not yet been released. This authorization expires in six (6) months unless another date is written here _____.

_____**PLEASE FAX ASAP, this is for immediate patient care! Fax Number**_____