

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

Homo Addross			First	Middle
Home Address.	Last		I 11 5t	Midule
Home Telephone:	D	ate of Birth:	Social Secu	rity Number:
	be Disclosed/Brief Desc	ription of PHI Disclosed: (C		
☐ Face sheet		☐ History and Physic		Purpose or use of Disclosure
☐ Lab test results, specify:		□ Discharge Summar	ry	☐ Continuity of Care
☐ Radiology test results, s	pecify:	Consultation		□ Personal
☐ Entire Medical Record		☐ Itemized bill or bil	ling information	□ Legal
☐ Emergency Room Reco	rd	☐ Discharge Medicat	tion List	☐ Insurance
		= Diseininge Friedren	2.50	Other:
Dates of service needed: _				
and/or disclosure of the type (May waive this section of	oe of highly confidential info not pertinent)	ential information listed below an rmation indicated next to my sign	nd signing on the app nature, if any such inf	ropriate line after the checked box, I specifically authorize the us formation will be used or disclosed pursuant to this Authorization
☐ Mental Illnes ☐ Developmen				
☐ Psychothera	py Notes			
☐ HÍV/AIDS T	Testing or Treatment (regardle	ess of result)		
□ Venereal Dis	sease			
	Adult with a Disability			
☐ Sexual Assar	ult			
☐ Child Abuse	or Neglect			
				UVER HOSPITAL may disclose my health information:
Name:				——————————————————————————————————————
Address:				
TERM: This authorization				
☐ Until Covere	ed Entity fulfills this request.	heday of		
				formation (including the highly confidential I selected above, if
any) during the term of this	s Authorization for the follow	ving specific purpose(s): Note: "at	t the request of the pa	atient" is sufficient if the patient is initiating this Authorization:
I understand that once CLI	EVELAND CLINIC INDIAN	RIVER HOSPITAL discloses m	v health information	
HOSPITAL cannot guaran applicable federal and state I understand the CLEVEL disclose of my health infor	tee that the recipient will not e law governing the use and of AND CLINIC INDIAN RIVI mation.	redisclose my health information isclose of my health information. ER HOSPITAL may, directly or in	to a third party. The	to the recipient, CLEVELAND CLINIC INDIAN RIVER third party may not be required to abide by this Authorization or nuneration from a third party in connection with the use or
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