

Tallahassee Memorial HealthCare, 1300 Miccosukee Road, Tallahassee, FL 32308

PATIENT INFORMATION Date(s) of Service Requested: ___/___/___ to ___/___/___	NAME: _____ DATE OF BIRTH: ___/___/___ LAST 4 NUMBERS OF SSN: _____ DAY PHONE: _____ ADDRESS: _____ CITY: _____ STATE: _____ ZIP CODE: _____		
RELEASING PARTY <i>(Who has the information you want released?)</i>	<input type="checkbox"/> Tallahassee Memorial Hospital <input type="checkbox"/> Tallahassee Memorial Behavioral Health Center <input type="checkbox"/> Tallahassee Memorial Rehabilitation Center <input type="checkbox"/> Tallahassee Memorial Cancer Center <input type="checkbox"/> Tallahassee Memorial Clinic/ Physician Partners (<i>specify location</i>) _____ <input type="checkbox"/> Tallahassee Memorial Wound Care <input type="checkbox"/> Tallahassee Memorial Urgent Care <input type="checkbox"/> Tallahassee Memorial Home Health Care <input type="checkbox"/> Other		
RECEIVING PARTY <i>(Where do you want the information sent? Who may have the information?)</i>	NAME: _____ ADDRESS: _____ DAY PHONE: _____ CITY: _____ STATE: _____ ZIP CODE: _____ FAX NUMBER: _____ (URGENT PATIENT CARE ONLY)		
HOSPITAL (check all that apply): <input type="checkbox"/> Hospital Summary <input type="checkbox"/> Discharge Summary <input type="checkbox"/> History and Physical <input type="checkbox"/> Consultation Reports <input type="checkbox"/> Operative Reports <input type="checkbox"/> Laboratory Reports <input type="checkbox"/> Radiology Reports/ X-Ray Reports <input type="checkbox"/> Pathology Reports <input type="checkbox"/> Entire Record (not including psychotherapy notes)	<input type="checkbox"/> Emergency Record <input type="checkbox"/> Cardiac Reports/ EKG <input type="checkbox"/> Other _____ OFFICE/CLINIC (check all that apply): <input type="checkbox"/> Office Visits <input type="checkbox"/> Immunizations <input type="checkbox"/> Physical Exam <input type="checkbox"/> Laboratory Reports <input type="checkbox"/> Radiology Reports <input type="checkbox"/> Clinic Summary <input type="checkbox"/> Other _____ <input type="checkbox"/> Entire Record (not including psychotherapy notes)	BEHAVIORAL HEALTH/SUBSTANCE ABUSE (check all that apply): <input type="checkbox"/> Hospital Summary <input type="checkbox"/> Discharge Summary <input type="checkbox"/> Assessments <input type="checkbox"/> Progress Notes <input type="checkbox"/> Laboratory Reports <input type="checkbox"/> Medications <input type="checkbox"/> Entire Record (not including psychotherapy notes)	
FORMAT: <input type="checkbox"/> USB/ CD <input type="checkbox"/> Paper <input type="checkbox"/> Email <input type="checkbox"/> Other _____	DELIVERY METHOD: <input type="checkbox"/> Mail <input type="checkbox"/> Pick-up <input type="checkbox"/> Fax, where permitted <input type="checkbox"/> Email (Print Clearly Below) Email: _____		
<p>PATIENT'S RIGHTS- I understand that: 1) I can cancel this permission at any time. I must cancel in writing to the Privacy Officer at the above address; 2) Any cancellation will apply only to information not yet released by facility or practice; 3) Once my health information is released, there is the potential for information disclosed pursuant to this authorization to be subject to re-disclosure by the recipient and no longer protected by applicable regulations; 4) Refusing to sign this form will not prevent my ability to get treatment; 5) TMH will not share or use my health information without my permission other than by ways listed in TMH's Notice of Privacy Practices or as required by law. The Notice of Privacy Practices is available at tmh.org; 6) A fee may be charged for providing the protected health information; 7) I have a right to receive a copy of this form upon my request.</p> <p>I DO NOT WANT TO RELEASE (check all that apply): <input type="checkbox"/> HIV/AIDS <input type="checkbox"/> GENETIC INFORMATION <input type="checkbox"/> SEXUALLY TRANSMITTED DISEASE (STD) <input type="checkbox"/> DRUG/ALCOHOL <input type="checkbox"/> MENTAL HEALTH</p> <p>This permission expires one year after the date of my signature unless another date or event is written here:</p> <p>Signature: _____ Print Name: _____ Date: _____</p> <p>Witness Signature: _____ Print Name: _____ Date: _____</p> <p>Note: If a minor consented for their outpatient treatment for pregnancy, STD or behavioral/ mental health without parental consent, the minor must sign this authorization. Note: If the patient lacks the legal capacity or is unable to sign, an authorized personal representative may sign this form. Check the box below to indicate the relationship/ authority (Written Proof May be Requested):</p> <input type="checkbox"/> Healthcare Agent/ POA <input type="checkbox"/> Guardian <input type="checkbox"/> Executor/Administrator/Attorney in Fact <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Adult Child <input type="checkbox"/> Affidavit Next of Kin <input type="checkbox"/> Other _____			