TALLAHASSEE MEMORIAL HEALTHCARE
1300 Miccosukee Road, Tallahassee, FL 32308

AUTHORIZATION FOR RELEASE OF INFORMATION

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 (***Who*** has the information you want released?)	□ Tallahassee Memorial Hospital □ Tallahassee Memorial Wound Care □ Tallahassee Memorial Behavioral Health Center □ Tallahassee Memorial Urgent Care □ Tallahassee Memorial Rehabilitation Center □ Tallahassee Memorial Home Health Care □ Tallahassee Memorial Cancer Center □ Other □ Tallahassee Memorial Clinic/ Physician Partners (*specify location)*_____
RECEIVING PARTY (***Where*** do you want the information sent? ***Who*** may have the information?)	NAME:_____ ADDRESS:_____DAY PHONE:_____ CITY:_____ STATE:_____ZIP CODE:_____ FAX NUMBER: _____**(URGENT PATIENT CARE ONLY)**

HOSPITAL (check all that apply):	**OFFICE/CLINIC (check all that apply):**	**BEHAVIORAL HEALTH/SUBSTANCE ABUSE (check all that apply):**
□ Hospital Summary □ Emergency Record □ Discharge Summary □ Cardiac Reports/ EKG □ History and Physical □ Other_____ □ Consultation Reports _____ □ Operative Reports _____ □ Laboratory Reports _____ □ Radiology Reports/ X-Ray Reports □ Pathology Reports □ Entire Record (not including psychotherapy notes)	□ Office Visits □ Immunizations □ Physical Exam □ Laboratory Reports □ Radiology Reports □ Clinic Summary □ Other_____ □ Entire Record (not including psychotherapy notes)	□ Hospital Summary □ Discharge Summary □ Assessments □ Progress Notes □ Laboratory Reports □ Medications □ Entire Record (not including psychotherapy notes)

FORMAT: □ USB/ CD □ Paper □ Other_____ **DELIVERY METHOD:** □ Mail □ Pick-up □ Fax, where permitted

PATIENT'S RIGHTS- I understand that: 1) I can cancel this permission at anytime. 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.

I DO NOT WANT TO RELEASE (check all that apply):

□ **HIV/AIDS** □ **GENETIC INFORMATION** □ **SEXUALLY TRANSMITTED DISEASE (STD)** □ **DRUG/ALCOHOL** □ **MENTAL HEALTH**

This permission expires one year after the date of my signature unless another date or event is written here:_____

Signature: _____ Print Name:_____ Date:_____

Witness Signature: _____ Print Name:_____ Date:_____

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):

□ Healthcare Agent/ POA □ Guardian □ Executor/Administrator/Attorney in Fact □ Spouse
□ Parent □ Adult Child □ Affidavit Next of Kin □ Other_____

Patient Label

Revised 7/7/16