

Instructions: Please complete form in its entirety. Items not checked or blanks unfilled are assumed to be non-applicable or specifically not authorized for release. The release is not valid unless signed and dated by patient or legally authorized representative.

I AUTHORIZE _____ TO DISCLOSE/RELEASE THE INFORMATION BELOW TO SARASOTA
MEMORIAL HEALTH CARE SYSTEM

I AUTHORIZE SARASOTA MEMORIAL HEALTH CARE SYSTEM TO DISCLOSE/RELEASE THE INFORMATION SPECIFIED BELOW FROM THE HEALTH RECORDS OF:

Patient's Name: _____			
_____	_____	_____	_____
_____	_____	_____	_____
Previous Name If Applicable: _____		Birth Date _____	Telephone # _____

THIS INFORMATION IS TO BE DISCLOSED/RELEASED TO: (Include Address)

COVERING THE FOLLOWING TIMEFRAME(S) OF HEALTHCARE SERVICES AND/OR CONDITIONS RELATED TO:

FOR THE PURPOSE OF: Continuing Treatment Billing Personal Pt. Verification of Statement or Bill Other: _____

THE FOLLOWING INFORMATION IS TO BE DISCLOSED/RELEASED:

- | | |
|--|---|
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Emergency Report |
| <input type="checkbox"/> Operative Report | <input type="checkbox"/> Abstract (Consultations, Discharge Medication Reconciliation Form, Discharge Summary, ED Physician Note, Face Sheet, History & Physical, Lab Results, Operative Report, Radiology Reports) |
| <input type="checkbox"/> History & Physical Examination | <input type="checkbox"/> Billing Records/Itemized Bill |
| <input type="checkbox"/> Laboratory Tests | <input type="checkbox"/> Billing Verification Abstract |
| <input type="checkbox"/> Consultation Reports | <input type="checkbox"/> Entire Medical Record – including all dates of service and any conditions treated |
| <input type="checkbox"/> Rehabilitation Documentation | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Photographs, Videotapes, other Media | |
| <input type="checkbox"/> Radiology Reports or Images <input type="checkbox"/> CD or <input type="checkbox"/> Email Link | |
| <input type="checkbox"/> Cardiology Reports or Images <input type="checkbox"/> CD or <input type="checkbox"/> Email Link | |
| Email address: _____ | |

I understand that this will include information relating to (initial if applicable):	
_____	Acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV) infection
_____	Mental Health
_____	Treatment for alcohol and/or drug abuse
_____	Sexually Transmitted Disease

POSSIBILITY OF REDISCLOSURE: I understand that any information released may be subject to re-disclosure and no longer protected by state and federal regulations.

EXPIRATION AND REVOCATION: I understand that this authorization is valid for 6 months from the date I sign it, or until _____ (date or event), not to exceed 24 months. I have the right to revoke this authorization in writing at any time. The revocation will take effect on the day it is received except to the extent it has already been acted upon or if the authorization was obtained as a condition of obtaining insurance coverage.

CONDITIONS OF TREATMENT: I understand that Sarasota Memorial Health Care System or agency cannot condition treatment upon my signing this authorization.

Signature of Patient or Legally Authorized Representative* Date

*If other than patient signing, state relationship: _____

Signature of Witness Date

SARASOTA MEMORIAL HEALTH CARE SYSTEM
 Sarasota Memorial Hospital First Physician's Group
AUTHORIZATION TO RELEASE PATIENT INFORMATION



HOSPITAL PERSONNEL ONLY:
Acknowledged by (signature/date): _____