

Patient Name: _____ Today's Date: _____

S.S. #: _____ DOB: _____ Unit #: _____

I authorize Shands Jacksonville to release a copy of the medical records to:

_____	_____
Name of person/hospital to receive information	Title (Physician, Attorney, etc) or ATTN:
_____	_____
Street Address	City, State, Zip Code
Date(s) of service _____	

INFORMATION TO BE RELEASED: (Please circle Yes or No for each category listed.)

- | | | |
|---------------------------------|---|--|
| Y N Medical History | Y N Operation Report(s) | Y N Mental Health Record(s) |
| Y N Medication Record(s) | Y N Treatment or Tests | Y N Alcohol, Drug Abuse Report(s) |
| Y N Laboratory Report(s) | Y N Consultations | Y N HIV Test Result(s) |
| Y N Pathology Report(s) | Y N Discharge Summary | Y N Sexually Transmitted Diseases |
| Y N X-Ray Report(s) | Y N Outpatient/Emergency Report(s) | Y N Specified Report Type _____ |

Purpose of this release is for: (Please check one or more)

- Continuity of care (i.e. doctor's office visit) Billing and payment of bill Other

I ACKNOWLEDGE I HAVE READ AND HAVE UNDERSTOOD THIS AUTHORIZATION AND ITS CONTENT.

I understand that these records are of a privileged and confidential status. I waive that status for the purpose contained within this authorization. I agree to hold Shands Jacksonville harmless from any and all costs, liability and damages of any nature whatsoever, including attorney's fees resulting directly or indirectly from Shands Jacksonville release of these records pursuant to this consent.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment, payment, enrollment or eligibility for benefits. I understand that I may inspect or copy the information to be used or disclosed as provided in CFR 164.524. I understand that any disclosure of the information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules.

This authorization may be revoked at any time. Each disclosure requires an additional signed authorization. If not previously revoked, this consent will terminate 6 months after the date of my signing this consent. Only original signed requests are valid.

_____	_____
Signature of Patient or Legal Representative	Date

_____	_____
If signed by legal representative, Relationship to Patient	Signature of Witness

To the recipient:
Prohibition of Redisclosure. The information is being disclosed to you from records whose confidentiality is protected by state laws, specifically Florida Statutes 395.3025, 455.667 and 394.459. State Laws prohibit you from mailing any further disclosure of this data without the specific written consent of the person to whom it pertains, or as otherwise permitted by State Regulations. A General Authorization is not sufficient for this purpose.

Information Sent:	For Office Use Only	ID Verified By:
Sign:		Sign:
Date:		Date:
For: <input type="checkbox"/> Pick up <input type="checkbox"/> Mail <input type="checkbox"/> Review		Type:



Authorization for Release of Information



Form # 190003
Page 1 of 1
Approved: 08/03
Revised:

