AUTHORIZATION TO OBTAIN OR RELEASE PROTECTED HEALTH INFORMATION

PARRISH HEALTHCARE

1. PATIENT AND REQUESTOR INFORMATION

PATIENT NAME: _____ DATE OF BIRTH: _____

STREET ADDRESS: _____ TELEPHONE #: _____

CITY, STATE, ZIP CODE: _____ EMAIL ADDRESS: _____

2. PERSON/FACILITY AUTHORIZED TO *OBTAIN* THE PROTECTED HEALTH INFORMATION:

☐ **Parrish Medical Center**
951 N. Washington Ave.
Titusville, FL 32796
Fax Number:
321-268-6280

Parrish Medical Group
☐ Titus Landing: 250 Harrison St., Titusville, FL 32780
☐ Port. St. John: 5005 Port St. John Pkwy, Port St. John, FL 32927
☐ Occ. Health Clinic: 494 N. Washington Ave., Titusville, FL 32796
Office/Dept: _____
Fax Number: _____

☐ Other (Specify Facility/Person/Address)
_____
_____
_____
Fax Number: _____

3. PERSON/FACILITY AUTHORIZED TO *RELEASE* THE PROTECTED HEALTH INFORMATION:

☐ **Parrish Medical Center**
951 N. Washington Ave.
Titusville, FL 32796
Fax Number:
321-268-6280

Parrish Medical Group
☐ Titus Landing: 250 Harrison St., Titusville, FL 32780
☐ Port. St. John: 5005 Port St. John Pkwy, Port St. John, FL 32927
☐ Occ. Health Clinic: 494 N. Washington Ave., Titusville, FL 32796
Office/Dept: _____
Fax Number: _____

☐ Other (Specify Facility/Person/Address)
_____
_____
_____
Fax Number: _____

4. The following PHI may be released *(check boxes below)*:

Covering the period(s) of health care from (date): _____ to (date): _____

☐ Hospital Abstract ☐ Office Abstract
☐ Radiology Reports ☐ Radiology Images
☐ Lab/Pathology Results ☐ Other / Specific Report: _____

I further authorize the release of the following information which may be included in the PHI (please initial):

_____ Behavioral health
_____ Substance Use Disorder
_____ STD/HIV/AIDS Treatment(s) or Test(s)
_____ Genetic Testing

Delivery of requested PHI: ☐ Pick up in person ☐ Deliver by Fax/Mail ***Radiology image requests:*** ☐ Disc given/sent to patient ☐ Disc sent to facility

☐ Please enroll me in the online Patient Health Portal. ☐ eDelivery to: (enter e-mail address)

Purpose of this request? ☐ Treatment/Continued Care ☐ Payment/Billing ☐ Personal Use ☐ Other: _____

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Health Information Management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date: _____

If I fail to specify an expiration date, this authorization will expire in one year.

I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosures of my health information, I can contact the privacy officer at 321-268-6835.

The facility, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Signed: _____ _____
(Patient or Legal Representative) (Date)/(Time)

_____ _____
(Signature of Witness) (Date)/(Time)