BOCA RATON REGIONAL HOSPITAL

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

Phone: **Fax:**

Patient Name:_____
Last 4 digits of the Social Security #:_____
Patient's Phone #:_____

DOB: _____
MR#: _____ **(HIM Personnel to fill out)**
Email: _____

I hereby authorize to release paper, electronic, medical, psychiatric, alcohol and/or drug abuse, HIV Testing, ARC and/or AIDS diagnosis, eating disorder information or any other records of a sensitive nature:

This will Authorize:

To Release to (Name):

_____

Address: _____

_____

Phone#: _____

This will Authorize:

_____

_____

_____

_____

To Release to:

Which format would you prefer:

☐ Paper Records ☐ Email ☐ PLEASE CHECK HERE IF YOU WILL BE PICKING UP
☐ CD ☐ Inspection YOUR MEDICAL RECORDS

Fee's:
Patient Connect - Free
Electronic format and/or Email - $6.50
Paper Records: $0.25 per page plus applicable postage and sales tax
CD format - $6.50 per disk plus applicable postage and sales tax.

Please disclose the exact information selected below:

___ Entire Medical Record,:_____

	Date(s) of Service:		Date(s) of Service:
___* Facesheet	_____	___* Laboratory Reports	_____
___* History and Physical	_____	___* Radiology Reports	_____
___* Discharge Summary	_____	___Progress Notes	_____
___* Consultations	_____	___ Physician Orders	_____
___* Operative Reports	_____	___Nurses Notes	_____
___* Pathology	_____	___ Medication Sheets	_____
___* Emergency Report	_____	___**Films/Images**	_____
___* EKG Report	_____	___Other (Specify) _____	

For the purpose of_____Expiration Date of this Authorization: **One Year**

To be completed by the patient or personal representative

I hereby authorize the use or disclosure of my protected health information as described above.

I understand that this authorization is voluntary. I understand that ability to obtain treatment will not be affected if I do not sign this form, unless that treatment is for a fitness-for-duty evaluation or a research-related treatment.

I understand that if the organization authorized to receive the information is not required to comply with the federal privacy protection regulations, then such information may be re-disclosed and will no longer be protected.

I understand that I have a right to revoke this authorization by sending written notification to:
Boca Raton Regional Hospital, **Attn: HIM, 634 Glades Road, Boca Raton, FL 33431**

Any revocation will not affect disclosures made prior to Boca Raton Regional Hospital's receipt or knowledge of the revocation.

I understand that I have a right to inspect and receive a copy of the information described on this form.

_____
Signature of patient or patient's representative/Power of Attorney Date

_____
Printed name of patient's representative/Power of Attorney Relationship to the patient

76860300

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Rev Date: 3/2019