



**AUTHORIZATION FOR  
RELEASE OF  
CONFIDENTIAL INFORMATION**

Phone: 561-955-4072 Fax: 561-955-4137

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

DOB: \_\_\_\_\_  
 MR#: \_\_\_\_\_  
 Email: \_\_\_\_\_  
 (HIM Personnel to fill out)

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:**  
 Boca Raton Regional Hospital  
 800 Meadows Road  
 Boca Raton, FL 33486  
**To Release to (Name):**

**This will Authorize:**  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Address:** \_\_\_\_\_  
 \_\_\_\_\_  
**Phone#:** \_\_\_\_\_

To Release to:  
 Boca Raton Regional Hospital  
 800 Meadows Road  
 Boca Raton, FL 33486

**Which format would you prefer:**

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

Records will automatically be mailed after 10 days unless there is a fee.

**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: \_\_\_\_\_     Rad / Images CD+DVD or Electronic format
- Abstract Medical Record: \_\_\_\_\_
- |  |                          |   |                          |
|--|--------------------------|---|--------------------------|
| <input type="checkbox"/> * Discharge Summary _____ | <b>Date Range:</b> _____ | <input type="checkbox"/> * Laboratory Reports _____ | <b>Date Range:</b> _____ |
| <input type="checkbox"/> * Operative Reports _____ | _____                    | <input type="checkbox"/> * Radiology Reports _____  | _____                    |
| <input type="checkbox"/> * Emergency Report _____  | _____                    | <input type="checkbox"/> * Pathology _____          | _____                    |
- 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.

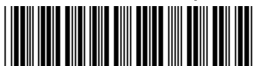
**I understand that I have a right to inspect and receive a copy of the information described on this form.**

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

Date

Printed name of patient's representative/Power of Attorney

Relationship to the patient



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