AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

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

Patient Name: ______________________________

DOB: ____________________

Last 4 digits of the Social Security #: __________

MR#: ____________________
(HIM Personnel to fill out)

Patient's Phone #: ______________________________

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

____

Address: ______________________________

____

Phone#: ______________________________

This will Authorize:

____

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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: ______________________________
- ❑ Abstract Medical Record: ______________________________
- ❑ **Rad / Images CD+DVD or Electronic format**

	Date Range:		Date Range:
❑ * Discharge Summary	__________	❑ * Laboratory Reports	__________
❑ * Operative Reports	__________	❑ * Radiology Reports	__________
❑ * Emergency Report	__________	❑ * 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.

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

____

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

Form ID: 768 **60300**
Rev Date: 4/2020