Authorization to Use or Disclose Protected Health Information

☐ BayCare Alliant Hospital
☐ BayCare Behavioral Health
☐ BayCare Hospital Wesley Chapel
☐ Bartow Regional Medical Center
☐ Mease Countryside Hospital
☐ Mease Dunedin Hospital
☐ Morton Plant Hospital
☐ Morton Plant North Bay Hospital
☐ Northside Behavioral Health
☐ St. Anthony's Hospital
☐ St. Joseph's Hospital
☐ St. Joseph's Children's Hospital
☐ St. Joseph's Women's Hospital
☐ St. Joseph's Hospital – North
☐ St. Joseph's Hospital – South
☐ South Florida Baptist Hospital
☐ Winter Haven Hospitals
☐ _____

I authorize the above facility to release medical, mental, alcohol and/or drug abuse, HIV (human immunodeficiency virus) testing, AIDS, eating disorders or any other medical information of a sensitive nature to the following individuals or organization(s):

Patient Information (Please Print)

First Name:	Middle Initial:	Last Name:	
Name at Time of Treatment (if different than above):			
Date of Birth (MM/DD/YYYY)		Phone:	
Street Address:	City:	State:	Zip:

What records do you want? (Check appropriate boxes below):
This information for which I'm authorizing disclosure will be used for the following purpose:

Description: _____

Date(s) of Service: _____/_____/_____ through _____/_____/_____

☐ Discharge Summary ☐ Emergency Room Record ☐ Operative/Procedure Report ☐ Visit Summary ☐ Billing Records

☐ Test Results (X-Rays, Lab/Pathology Results) Please specify: _____ ☐ Psychotherapy Notes

☐ Other (Immunization Records, Medication Lists) Please specify: _____ ☐ Psychiatric Evaluation ☐ Treatment Plan

How would you like your records delivered? (Choose one)

☐ Paper ☐ CD ☐ Mail or ☐ In-Person Pickup	☐ Electronic (Must have BayCare Patient Portal Account) ☐ Patient Portal

Where do you want the information sent? (Fill in boxes below):

Name:	Phone:
Mailing Address:	Fax:

I understand that if the organization authorized to receive the information is not a health plan or healthcare provider, the release information may no longer be protected by Federal privacy regulations. I understand that I need not sign this authorization to ensure treatment. This authorization shall remain valid for 1 year from the date signed below.

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 department or facility listed on the authorization. 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.

Signed: _____ Date: _____ Time: _____

Patient or Authorized Person, ☐ Parent ☐ Legal Guardian ☐ Executor ☐ Power of Attorney

☐ Photo ID checked

Witness: _____ Date: _____ Time: _____

Copied by: _____ Date: _____ Time: _____ Pages copied: _____

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PATIENT