Instructions: Please complete form in its entirety. Items not checked or blanks unfilled are assumed to be non-applicable or specifically not authorized for release. The release is not valid unless signed and dated by patient or legally authorized representative.

❑ **I AUTHORIZE** _____ **TO DISCLOSE/RELEASE THE INFORMATION BELOW TO SARASOTA MEMORIAL HEALTH CARE SYSTEM**
NAME OF FACILITY

❑ **I AUTHORIZE SARASOTA MEMORIAL HEALTH CARE SYSTEM TO DISCLOSE/RELEASE THE INFORMATION SPECIFIED BELOW FROM THE HEALTH RECORDS OF:**

Patient's Name: _____
Last First MI

Previous Name If Applicable: _____ Birth Date_____ Telephone #_____

THIS INFORMATION IS TO BE DISCLOSED/RELEASED TO: (Include Address)

_____

_____

_____

COVERING THE FOLLOWING TIMEFRAME(S) OF HEALTHCARE SERVICES AND/OR CONDITIONS RELATED TO:

_____

FOR THE PURPOSE OF: ❑ Continuing Treatment ❑ Billing ❑ Personal ❑ Pt. Verification of Statement or Bill ❑ Other: _____

THE FOLLOWING INFORMATION IS TO BE DISCLOSED/RELEASED:

❑ Discharge Summary
❑ Operative Report
❑ History & Physical Examination
❑ Laboratory Tests
❑ Consultation Reports
❑ Rehabilitation Documentation
❑ Photographs, Videotapes, other Media
❑ Radiology Reports or Images ❑ CD or ❑ Email Link
❑ Cardiology Reports or Images ❑ CD or ❑ Email Link
Email address:_____
❑ Emergency Report
❑ Abstract (Consultations, Discharge Medication Reconciliation Form, Discharge Summary, ED Physician Note, Face Sheet, History & Physical, Lab Results, Operative Report, Radiology Reports)
❑ Billing Records/Itemized Bill
❑ Billing Verification Abstract
❑ Entire Medical Record – including all dates of service and any conditions treated
❑ Other:_____

I understand that this will include information relating to (initial if applicable):
_____ Acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV) infection
_____ Mental Health
_____ Treatment for alcohol and/or drug abuse
_____ Sexually Transmitted Disease

POSSIBILITY OF REDISCLOSURE: I understand that any information released may be subject to re-disclosure and no longer protected by state and federal regulations.

EXPIRATION AND REVOCATION: I understand that this authorization is valid for 6 months from the date I sign it, or until _____ (date or event), not to exceed 24 months. I have the right to revoke this authorization in writing at any time. The revocation will take effect on the day it is received except to the extent it has already been acted upon or if the authorization was obtained as a condition of obtaining insurance coverage.

CONDITIONS OF TREATMENT: I understand that Sarasota Memorial Health Care System or agency cannot condition treatment upon my signing this authorization.

_____ _____
Signature of Patient or Legally Authorized Representative* Date

*If other than patient signing, state relationship: _____

_____ _____
Signature of Witness Date

SARASOTA MEMORIAL HEALTH CARE SYSTEM
❑ Sarasota Memorial Hospital ❑ First Physicians Group

AUTHORIZATION TO RELEASE PATIENT INFORMATION

HOSPITAL PERSONNEL ONLY:
Acknowledged by (signature/date):

_____

910532 Rev. 06/19

MR#_____

Processed: ❑ Yes ❑ No **Number of pages:** ____