**Section A: Authorization for Release of Protected Health Information (PHI) (PLEASE WRITE LEGIBLY)**

| **Patient Name:** | **Birth Date:** | **Please select preferred delivery method:** ☐ **Email** ☐ **Mail** |
|---|---|---|
| | | **Medical Records Dept Phone: 561-798-8680 Fax: 561-798-8578** |

**Recipient Name** (Person or organization that will receive your information):

**Patient's Email Address:**

**Address:**

**Fax # (For a Physician or Hospital):**

| **Apt. #:** | **City:** | **State:** | **Zip:** |
|---|---|---|---|
| | | | |

This authorization will expire in 60 days or on the following: (Fill in the Date or the Event but not both.)

☐ **Date:** _____ **or** ☐ **Event:** _____

**Description of information to be used or disclosed**

Is this request for psychotherapy notes? ☐ Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. ☐ No, then you may check as many items below as you need.

| Description: | Date(s) of Service: | Description: | Date(s) of Service: | Other: |
|---|---|---|---|---|
| ☐ Abstract of Medical Records:<br>☐ Consultations:<br>☐ Discharge Instructions:<br>☐ Discharge Summary:<br>☐ ER Record:<br>☐ History and Physical:<br>☐ Image Reports: | | ☐ Lab Reports:<br>☐ Medication Records:<br>☐ Operative Report:<br>☐ Physician Orders:<br>☐ Progress Notes:<br>☐ Rhythm Strips: | | ☐ Billing Records, Please call 866-772-6309<br>☐ Radiology Image CD, Please call the radiology department at 561-798-8514, Images cannot be emailed |

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. _____ (Initial)

I understand that:

- I may refuse to sign this authorization and that it is strictly voluntary.
- If I do not sign this form, my health care and the payment for my health care will not be affected unless stated otherwise in section C.
- I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation.
- Further details may be found in the Notice of Privacy Practices.
- If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
- I understand that I may see and obtain a copy the information described on this form, for a reasonable copy fee, if I ask for it.
- I get a copy of this form after I sign it.

**Section B: Is the Requester of this PHI another health plan, health care provider or purpose of marketing?** ☐ **No** ☐ **Yes**

If yes, the health plan, health care provider or marketing company must complete Section B, otherwise skip to Section C.

What is the purpose of this use or disclosure?

Will the requester receive financial or in-kind compensation in exchange for using or disclosing this information? ☐ Yes ☐ No

If yes, describe:

**Section C: Will the PHI be created for research and include treatment of the Patient?** ☐ **No** ☐ **Yes**

If yes, complete Section C below otherwise skip to Section D.

Describe the extent to which the PHI will be used or disclosed to carry out treatment, payment or health care operations?

Describe the disclosures that will NOT be made even if they are permitted by law.

Will the Requester plan to obtain the Patient's consent and/or provide a notice of privacy practices? ☐ Yes, then all statements above are binding. ☐ No

**Section D: Signatures (This section must be completed)**

I have read the above and authorize the disclosure of the protected health information as stated.

| **Signature of Patient/Guardian/Representative:** | **Date:** |
|---|---|
| **Print Name of Patient/Guardian/Representative:** | **Relationship to Patient:** |

Wellington Regional Medical Center
10101 Forest Hill Boulevard
Wellington, Florida 33414

**RELEASE OF INFORMATION**

RI0010

791-01
Rev. 02/22

Patient Identification