

# Authorization to use and disclose health information

(Request copies of medical records)

## Health Information Management

*For Cape Canaveral Hospital, Holmes Regional Medical Center, Palm Bay Community Hospital, and their affiliates.*

Patient name \_\_\_\_\_ Date(s) of service requesting \_\_\_\_\_

Date of birth \_\_\_\_\_ SSN# \_\_\_\_\_

- I authorize the use or disclosure of the above named individual's health information as described below.
- The type of information to be used or disclosed (check the appropriate items and include other information as needed) is:  
 History and physical       ER record       Discharge summary       Radiology reports  
 Cardiology reports       Physician orders       Progress notes       Entire medical record  
 Lab results (specify dates) \_\_\_\_\_  
 Consultation report(s) by \_\_\_\_\_  
 Other (please specify, i.e., vascular lab, pulmonary or other ancillary visits) \_\_\_\_\_
- I understand the health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.
- I authorize Health First, Inc. to make the disclosure to the individual or organization identified below.
- The items indicated above may be used by or disclosed to the following individual or organization:  
Name \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_  
Address \_\_\_\_\_
- This information for which I am authorizing disclosure will be used for the following purpose:  
 My personal records       Continued care/Dr. \_\_\_\_\_       Legal purpose  
 Other, please describe \_\_\_\_\_
- I understand I have the 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 Health Information Management Department where my information is maintained. 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.
- This authorization will expire six months from the date signed, which will be (date) \_\_\_\_\_. (If the expiration date of this authorization is not completed, this authorization will expire six months from the date of which it was signed.)
- I understand that once the above information is disclosed, it may be redisclosed by the recipient and the information may not be protected by federal privacy laws or regulations.
- I understand authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment.
- If I have questions about disclosure of my health information, I can contact the Health Information Management (Medical Records) Department where I received treatment.

Signature of patient or legal representative

Date

Relationship to patient (if signed by legal representative)

Documentation establishing relationship (specify document)

Signature of witness

Date

# Instructions for authorizing use and disclosure of health information

(Requesting copies of medical records)

To request copies of your medical records, complete this form and send it to the Health Information Management Department at the facility where you received treatment. This form must be signed and can be submitted by fax, mail, or in person (addresses and fax numbers are listed below). Verification of identity is required. Please allow 4 working days for the request to be processed.

**If you are requesting copies for someone other than yourself**, you will need to provide legal documentation verifying guardianship, power of attorney, executorship, or next-of-kin relationship of a decedent. Parents may request copies of their minor child's records if they have legal custody of the child and the child is not legally emancipated.

**To request copies for your primary care physician or other health care provider**, submit this form designating the physician or providers as the recipient of the copies. The copies will be sent directly to them.

## **Cape Canaveral Hospital**

Attention: Health Information Mgt.  
701 West Cocoa Beach Causeway  
Cocoa Beach, FL 32931

**Fax:** 321-799-7138

**Hours:** Monday through Friday,  
8 am to 4:30 pm

**Office location:** On the second floor of the hospital, near the administrative offices.

## **Holmes Regional Medical Center**

Attention: Health Information Mgt.  
1350 South Hickory Street  
Melbourne, FL 32901

**Fax:** 321-434-1877

**Hours:** Monday through Friday,  
8:30 am to 4 pm

**Office location:** On the first floor of the hospital, in the main hall between the cafeteria and the north entrance.

## **Palm Bay Community Hospital**

Attention: Health Information Mgt.  
1425 Malabar Road NE  
Palm Bay, FL 32907

**Fax:** 321-434-8104

**Office location:** The HIM Department takes requests for medical information through the reception desk next to the Emergency Department at the hospital.