

Section A: This section must be completed for all Authorizations

Patient Name:	Date of Birth:	Patient's Phone:	Last 4 digit SSN (optional)
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Provider's Name: Osceola Regional Medical Ctr.	Recipient's Name:
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Provider's Address: 700 West Oak Street Kissimmee, FL 34741	Address 1:		
	Address 2:	Recipient's Phone:	Recipient's Fax No:
	City:	State:	Zip:

Request Delivery (If left blank, a paper copy will be provided): Paper Copy Electronic Media, if available (e.g., USB drive, CD/DVD) Encrypted Email Unencrypted Email
NOTE: In the event the facility is unable to accommodate an electronic delivery as requested, an alternative delivery method will be provided (e.g., paper copy). There is some level of risk that a third party could see your PHI without your consent when receiving unencrypted electronic media or email. We are not responsible for unauthorized access to the PHI contained in this format or any risks (e.g., virus) potentially introduced to your computer/device when receiving PHI in electronic format or email.

Email Address (If email checked above. Please print legibly):

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

Purpose of disclosure:

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):	Description:	Date(s):	Description:	Date(s):
<input type="checkbox"/> All PHI in medical record		<input type="checkbox"/> Operative information		<input type="checkbox"/> Labor/delivery summary	
<input type="checkbox"/> Admission form		<input type="checkbox"/> Cath lab		<input type="checkbox"/> OB nursing assess	
<input type="checkbox"/> Dictation reports		<input type="checkbox"/> Special test/therapy		<input type="checkbox"/> Postpartum flow sheet	
<input type="checkbox"/> Physician orders		<input type="checkbox"/> Rhythm strips		<input type="checkbox"/> Itemized bill:	
<input type="checkbox"/> Intake/outtake		<input type="checkbox"/> Nursing information		<input type="checkbox"/> UB-04:	
<input type="checkbox"/> Clinical test		<input type="checkbox"/> Transfer forms		<input type="checkbox"/> Other:	
<input type="checkbox"/> Medication sheets		<input type="checkbox"/> ER information		<input type="checkbox"/> Other:	

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, genetic information, 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.
 - My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.
 - 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 request of PHI for the purpose of marketing and/or does it involve the sale of PHI? Yes No

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

Will the recipient receive financial remuneration in exchange for using or disclosing this information? If yes, describe:	<input type="checkbox"/> Yes <input type="checkbox"/> No
May the recipient of the PHI further exchange the information for financial remuneration?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Section C: Signatures

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

Signature of Patient/Patient's Representative:	Date:
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Print Name of Patient's Representative:	Relationship to Patient:
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