AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

Phone: 561-955-5000 Fax: 561-955-2948

Patient Name: ______________________ DOB: ____________

Last 4 digits of the Social Security #: ______________ MR#: ____________ (HIM Personnel to fill out)

Patient's Phone #: ______________________

I authorize to release paper, electronic, medical, physchiatric, alcohol and/or drug abuse, HIV testing, ARC and/or AIDS diagnosis, eating disorder information or any other records of a sensitive nature:

This will Authorize:
Boca Raton Regional Hospital
800 Meadows Road
Boca Raton, FL 33486

To Release to: **Name:** ______________________

Address: ______________________

____

Phone#: ______________________

This will Authorize:

____

____

____

____

To Release to:
Boca Raton Regional Hospital
800 Meadows Road
Boca Raton, FL 33486

Which format would you prefer:

- ❑ Paper Records
- ❑ Patient Connect
- ❑ CD

Please disclose the exact information selected below:

___ Entire Medical Record, excluding: ______________________

	Date(s) of Service:
___ * Facesheet	________
___ * History and Physical	________
___ * Discharge Summary	________
___ * Consultations	________
___ * Operative Reports	________
___ * Pathology	________
___ * Emergency Report	________
___ * EKG Report	________

	Date(s) of Service:
___ * Laboratory Reports	________
___ * Radiology Reports	________
___ Progress Notes	________
___ Physician Orders	________
___ Nurses Notes	________
___ Medication Sheets	________
___ **Films/Images**	________
___ Other (Specify)	________

For the purpose of ______________________ Expiration Date of this Authorization: **One Year**

To be completed by the patient or personal representative

I hereby authorize the use or disclosure of my protected health information as described above.

I understand that this authorization is voluntary. I understand that ability to obtain treatment will not be affected if I do not sign this form, unless that treatment is for a fitness-for-duty evaluation or a research-related treatment.

I understand that if the organization authorized to receive the information is not required to comply with the federal privacy protection regulations, then such information may be re-disclosed and will no longer be protected.

I understand that I have a right to revoke this authorization by sending written notification to:
Boca Raton Regional Hospital, **Attn: HIM, 634 Glades Road, Boca Raton, FL 33431.**
Any revocation will not affect disclosures made prior to Boca Raton Regional Hospital's receipt or knowledge of the revocation.
I understand that I have a right to inspect and receive a copy of the information described on this form.

____
Signature of patient or patient's representative/Power of Attorney — Date

____
Printed name of patient's representative/Power of Attorney — Relationship to the patient

Form ID: 768 **60300**
Rev Date: 5/2014