Authorization for Use or Disclosure of Protected Health Information

I hereby authorize Moffitt Cancer Center Institute to Release my Medical Records/Protected Health Information to the specify person or organization listed below:

Name or organization:	Fax:	Phone:
Email:	Mailing address:	

Information to be disclosed: (please check the appropriate boxes)
Date(s) of Service:_____ ***or*** from:_____ to: _____

[ ] Abstract (discharge summary, history/physical, consultation reports, operative reports, labs, radiology, pathology report, EKG's)

[ ] Billing Records [ ] History & Physical [ ] Outside Records [ ] Physician Orders

[ ] Consultation Reports [ ] Laboratory Results [ ] Pathology Reports [ ] Progress Notes

[ ] Discharge Summary [ ] Nursing Data/Notes [ ] Operative Reports [ ] Radiology Reports

[ ] Genetic Records _____ *initials* [ ] Imaging CT PET Mammogram Ultrasound MRI X-Ray

[ ] My entire medical record held by the Center, including, but not limited to, HIV/AIDS, substance abuse or genetic information, except for information that I expressly exclude below. (**excluding** mental health/psychotherapy notes a separate release must be completed to obtain these records),

[ ] Other specific record(s). Please describe:_____

[ ] **Exclude** the information expressly listed below (if blank, then no information is excluded):

Purpose of Disclosure: The above information is released for the following purpose *(please check the appropriate box)*

[ ] Transfer of medical care [ ] Legal/Attorney use [ ] Personal [ ] Insurance use [ ] Continuity of care

[ ] Other (please specify):

This authorization will expire on:_____. If no date is given, this authorization will expire in 90 days. Records being released to patients may stay active for up to 1 (one) year from the date signed all other recipients can stay active for up 90 days from the date the release is signed.

I understand in compliance with Florida law, there may be fees for requesting copies of my medical record. I understand I may revoke this Authorization at any time by notifying the Health Information Management (HIM) Department of the Center in writing, except to the extent that the Hospital has taken action in reliance on this Authorization. I understand that I may refuse to sign this Authorization and that my refusal to sign will not affect my ability to obtain treatment, payment, or my eligibility for benefits. I understand the information disclosed under this Authorization may be subject to redisclosure by the recipient and no longer protected by federal privacy regulations or other privacy laws. I understand by signing this Authorization I authorize the Hospital to disclose the information identified above.

_____ _____

Signature of Patient or Personal Representative Date Printed Name of Patient or Personal Representative Date

_____

Description of Personal Representative Date

MOFFITT CANCER CENTER

12202-1-0308 07/2019

EMR: Release of Information
12902 Magnolia Dr. Tampa Fl 33612 MBC-HIM
PHONE: 813-745-3991 FAX 813-449-8001
Medicalrecordrequest@moffitt.org

Patient Name: _____

Date of Birth: _____

MRN: _____