

Authorization for Use or Disclosure of Protected Health Information

(THIS FORM MUST BE COMPLETED IN FULL.)

I request **H. Lee Moffitt Cancer Center & Research Institute (the Center)** to release

TO: _____
(Name of Provider or Individual TO RECEIVE Information)

(Address)

THE FOLLOWING INFORMATION (Select any or all):

My entire medical record held by the Center, including, but not limited to, HIV/AIDS, mental health (excluding psychotherapy notes), substance abuse or genetic information, except for information that I expressly exclude below.

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

My billing record(s).

Other specific record(s). Please describe: _____

FOR THE DATES: All dates of care and treatment **OR** From _____ Through _____.

FOR THE FOLLOWING PURPOSE: _____
(If none given, it is at the request of the patient.)

THIS AUTHORIZATION WILL EXPIRE ON: _____.

(If no date given, authorization will expire in ninety (90) days.)

SPECIFIC UNDERSTANDINGS:

I understand that in compliance with Florida law, there may be a fee of \$1 per page for requesting copies of my medical record. Postage will be charged, if applicable.

I understand that I may revoke this Authorization at any time by notifying the Health Information Management (HIM) Department of the Center in writing (12902 Magnolia Drive, Tampa, FL 33612, Attention: HIM Department), 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 that 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 that by signing this Authorization I authorize the Hospital to disclose the information identified above and related information necessary to accomplish the purpose described above.

Signature of Patient or Personal Representative

Date

Print Name of Patient or Personal Representative

Description of Personal Representative's Authority

Date of Birth

(A copy of this signed form will be provided to the patient or his/her personal representative.)



12902 Magnolia Dr
Tampa, FL 33612
HIM PHONE: 813-745-3991 FAX 813-449-8001



EMR: Release of Information Consent

Patient Name: _____
Medical Record No.: _____