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.)

MOFFITT CANCER CENTER
12902 Magnolia Dr
Tampa. FL 33612
HIM PHONE: 813-745-3991 FAX 813-449-8001
12202-1-0308 09/07
EMR: Release of Information Consent

Patient Name: _____

Medical Record No.: _____