HALIFAX HEALTH
HALIFAX HEALTH/UF HEALTH
Daytona Beach | Port Orange | Deltona
Full location list available at halifaxhealth.org/locations

Patient Name
Adm. Date Dr.
Date of Birth Age Sex
MR # Visit #

SPECIAL AUTHORIZATION TO RELEASE INFORMATION

Health Information Management

Hours: 8 a.m. − 4:30 p.m. Monday−Friday

Phone: (386) 425−4701 • Fax: (386) 425−4741

Patient Name ______________________ Medical Record # ______________

Address ______________________ Phone # ______________

Date of Birth ____________ Date Information Needed ___/___/___ ❏Mail ❏Pick Up ❏Fax # ______________ (PHYS/FACILITY)

❏Paper ❏CD ❏Email − Valid Email Address Required: ______________________

I hereby authorize Halifax Health to use and **disclose to**: ❏or **obtain from**: ❏

______________________ ______________
NAME OF FACILITY OR PERSON PHONE

____
STREET ADDRESS CITY STATE ZIP

the following information contained in my medical record regarding my hospitalization, care and treatment:

❏Entire Medical Record ❏History & Physical ❏Consultants Reports ❏Medication Record
❏Discharge Summary ❏Psychosocial Assessment ❏Pathology Reports
❏Laboratory Results ❏Treatment Plan ❏Operative Reports
❏Pertinent Information (reports and test results) ❏Other (please specify) ______________

Date(s) of Service: ______________________

The purpose for release of information at the request of the individual is:
❏Insurance ❏Legal action ❏Continuing care ❏Other (specify) ______________

I understand that this authorization extends to all or any part of the records designated above, which may include psychiatric information, and/or alcohol/drug abuse, and/or AIDS (Acquired Immunodeficiency Syndrome), and/or may include the result of an HIV test or the fact that an HIV test was performed. I expressly consent to the release of information as designed above unless checked below. I understand this authorization extends to release of information via U.S. mail, telephone or facsimile machine (fax).

May NOT include information related to: ❏HIV/AIDS ❏Mental Health ❏Substance Abuse (Alcohol/Drugs) ❏Genetic Testing

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the **Health Information Management Department at 303 N Clyde Morris Blvd, Daytona Beach, FL 32114.** I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. This authorization shall remain in effect for a period not to exceed twelve (12) months from the date of execution, unless an expiration date/event is indicated or revoked earlier by me through written notice.

I understand that authorizing the disclosure of this health information is voluntary. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and federal confidentiality laws or regulations may not protect the information. If I have questions about disclosure of my health information, I can contact the Halifax Health Privacy Official by calling the number listed at the top of this page and asking to be referred to the office of the Privacy Official.

______________________ ______________
SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE DATE

____
IF SIGNED BY LEGAL REPRESENTATIVE, DESCRIPTION OF AUTHORITY TO ACT ON BEHALF OF THE INDIVIDUAL

FEES FOR REPRODUCTION ARE AVAILABLE UPON REQUEST

This information is being disclosed to you from records whose confidentiality is protected by Fed. Law 42CFR, part 2, which prohibits you from making any further disclosure without the specific written consent of the person to whom it pertains. A general authorization for the release of medical or other information is NOT sufficient for this purpose.