HALIFAX HEALTH − CHILDREN'S MEDICAL CENTER

Phone (386) 425−1212 • Fax (386) 425−1213

❑ 200 Booth Rd., Ste. A, Ormond Beach, FL 32174
❑ 57 Town Court, Ste. 216, Palm Coast, FL 32164
❑ 870 Dunlawton Ave. Ste. 310, Port Orange, FL 32127

SPECIAL AUTHORIZATION TO RELEASE INFORMATION

Today's Date:_____

Patient Name _____ Medical Record # _____

Address _____ Phone # _____

Date of Birth _____ Date Information Needed ____/____/____

I hereby authorize Halifax Health − Children's Medical Center 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:

❑ Emergency Record ❑ Radiology Reports ❑ Pathology Reports ❑ Medication Record ❑ Physical Exam and
❑ Discharge Summary ❑ History & Physical ❑ Operative Reports ❑ Immunizations Growth Chart
❑ Laboratory Results ❑ Consultants Reports ❑ Psychosocial Assessment ❑ Last 2 Years of Records Only
❑ Pertinent Information (reports and test results) ❑ Treatment Plan ❑ Other (please specify) _____

NOTE: Please mail, do not fax, if more than 25 pages of records.

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 **Halifax Health − Childen's Medical Center, 200 Booth Rd., Suite A, Ormond Beach, FL 32174.** 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. Unless otherwise revoked, this authorization will expire on the following date, event, or condition:_____. If I fail to specify an expiration date, event or condition, this authorization will expire in six months.

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