HALIFAX HEALTH

CENTER FOR TRANSPLANT SERVICES

311 N. Clyde Morris Blvd., Suite 360, Daytona Beach, FL 32114
(386) 425−4650 • Fax (386) 425−7510

SPECIAL AUTHORIZATION TO RELEASE INFORMATION

INSTRUCTIONS: Please complete only the sections with an asterisk (*).

* Patient Name _____

* Address _____ * Phone # _____

* Date of Birth _____ Date Information Needed ____/____/____ Mail____ Pick Up____ * Fax # 386-425-7510
(PHYS/FACILITY)

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:

❑ Emergency Record ❑ Radiology Reports ❑ Pathology Reports ❑ Treatment Plan
❑ Discharge Summary ❑ History & Physical ❑ Operative Reports ❑ Medication Record
❑ Laboratory Results ❑ Consultants Reports ❑ Psychosocial Assessment
❑ Pertinent Information (includes above) ❑ 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) Kidney Transplant Assessment

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. 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 at (386) 254−4040, ext. 3161.

* _____ _____
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.


TRANS 1