Instructions: Please complete form in its entirety. Items not checked or blanks unfilled are assumed to be non-applicable or specifically not authorized for release. The release is not valid unless signed and dated by patient or legally authorized representative.

❑ **I AUTHORIZE** ________________________________ **TO DISCLOSE/RELEASE THE INFORMATION BELOW TO SARASOTA MEMORIAL HEALTH CARE SYSTEM**
NAME OF FACILITY

❑ **I AUTHORIZE SARASOTA MEMORIAL HEALTH CARE SYSTEM TO DISCLOSE/RELEASE THE INFORMATION SPECIFIED BELOW FROM THE HEALTH RECORDS OF:**

Patient's Name: ____
Last First MI

Previous Name If Applicable: ______________________ Birth Date__________ Telephone #______________

THIS INFORMATION IS TO BE DISCLOSED/RELEASED TO: (Include Address)

____

____

____

COVERING THE FOLLOWING TIMEFRAME(S) OF HEALTHCARE SERVICES AND/OR CONDITIONS RELATED TO:

____

FOR THE PURPOSE OF: ❑ Continuing Treatment ❑ Billing ❑ Personal ❑ Pt. Verification of Statement or Bill ❑ Other: __________

THE FOLLOWING INFORMATION IS TO BE DISCLOSED/RELEASED:

- ❑ Discharge Summary
- ❑ Operative Report
- ❑ History & Physical Examination
- ❑ Laboratory Tests
- ❑ Consultation Reports
- ❑ Rehabilitation Documentation
- ❑ Photographs, Videotapes, other Media
- ❑ Radiology Reports or Images ❑ CD or ❑ Email Link
- ❑ Cardiology Reports or Images ❑ CD or ❑ Email Link

Email address:________________________________

- ❑ Emergency Report
- ❑ Abstract (Consultations, Discharge Medication Reconciliation Form, Discharge Summary, ED Physician Note, Face Sheet, History & Physical, Lab Results, Operative Report, Radiology Reports)
- ❑ Billing Records/Itemized Bill
- ❑ Billing Verification Abstract
- ❑ Entire Medical Record – including all dates of service and any conditions treated
- ❑ Other:________________________________

I understand that this will include information relating to (initial if applicable):

__________ Acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV) infection
__________ Mental Health
__________ Treatment for alcohol and/or drug abuse
__________ Sexually Transmitted Disease

POSSIBILITY OF REDISCLOSURE: I understand that any information released may be subject to re-disclosure and no longer protected by state and federal regulations.

EXPIRATION AND REVOCATION: I understand that this authorization is valid for 6 months from the date I sign it, or until ________________________ (date or event), not to exceed 24 months. I have the right to revoke this authorization in writing at any time. The revocation will take effect on the day it is received except to the extent it has already been acted upon or if the authorization was obtained as a condition of obtaining insurance coverage.

CONDITIONS OF TREATMENT: I understand that Sarasota Memorial Health Care System or agency cannot condition treatment upon my signing this authorization.

____ ____________________
Signature of Patient or Legally Authorized Representative* Date

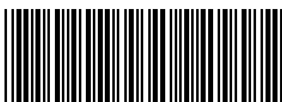
*If other than patient signing, state relationship: ____

____ ____________________
Signature of Witness Date

SARASOTA MEMORIAL HEALTH CARE SYSTEM

❑ SMH-Sarasota ❑ SMH-Venice ❑ First Physicians Group

AUTHORIZATION TO RELEASE PATIENT INFORMATION



HOSPITAL PERSONNEL ONLY:
Acknowledged by (signature/date):

____

910532 Rev. 11/2021

MR#____________________

Processed: ❑ Yes ❑ No **Number of pages:** _____