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** _____ (Facility) **TO DISCLOSE/RELEASE THE INFORMATION BELOW TO**
NAME OF FACILITY
SARASOTA MEMORIAL HEALTH CARE SYSTEM

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

❑ **SMH-Sarasota** ❑ **SMH-Venice** ❑ **SMH-Urgent Care Centers** ❑ **First Physicians Group**

Patient's Name: _____
Last First MI

Previous Name If Applicable: _____ Birth Date_____ Telephone #_____

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

Recipient Name: _____

Recipient Address: _____

Recipient Phone #_____ Recipient Fax: _____

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

_____

FOR THE PURPOSE OF: ❑ Continuing Treatment ❑ At the Request of the Patient ❑ Third Party Recipient – Specify Purpose:_____

THE FOLLOWING INFORMATION IS TO BE DISCLOSED/RELEASED:

❑ **All Clinical Pertinent Documents**

❑ **All Pertinent Imaging** (includes those listed below):
- ❑ Radiology Images on CD or ❑ Electronic Link to Image
- ❑ Cardiology Images on CD or ❑ Electronic Link to Image

Email address:_____

❑ **Billing Records**
- ❑ Itemized Bill
- ❑ Billing Verification Abstract
- ❑ Good Faith Estimate (EPRO)

❑ **Other (Please Specify)**

_____

VIA THE FOLLOWING FORMAT:

❑ **Encrypted email to:** _____ ❑ **Fax** ❑ **Mail to Specified Address** ❑ **Pick-up in Person**

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

_____ Behavioral Health
_____ Substance Use Disorder Treatment
_____ Sexually Transmitted Disease / Acquired immunodeficiency syndrome (AIDS) /Human Immunodeficiency Virus (HIV) treatment or testing
_____ Genetic Testing

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 by contacting SARASOTA MEMORIAL HOSPITAL, ATTENTION: HEALTH INFORMATION MANAGEMENT SERVICES, 1700 S. Tamiami Trail, Sarasota, FL 34239-9989. 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. **Note: This authorization will be processed at the time of receipt and only relates to releasing what is on this specific request.**

CONDITIONS OF TREATMENT: I understand that Sarasota Memorial Health Care System (or the Facility) cannot condition treatment, payment, enrollment in a health plan, or eligibility for benefits for health care 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

AUTHORIZATION TO RELEASE PATIENT INFORMATION

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

_____

910532 Rev. 10/2024

MR#_____

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