AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION (PHI)

Place MCC Label Here or Complete Section One Below

Attention: Release of Information
Attn: Release of Information Department
8333 North Davis Highway
Pensacola, FL 32514
Phone: 850-474-8299
Fax: 850-474-8022

SECTION ONE:

Patient's Name (First and Last) **Print Legibly**		Social Security Number		Date of Birth	**For Release of Information Use Only** Verification of Identity Confirmed: ☐ Driver's License ☐ Password ☐ Other___________________
Patient's Street Address	City	State	Zip Code	MCC Patient Number	

Complete this section only if the person authorizing the use and disclosure is NOT the patient:

Representative's Name (First and Last) **Print Clearly and Legibly**			Relationship to Patient	Legal Authority
Representative's Street Address			Verification of Identity	Verification of Authority
City	State	Zip Code	Telephone Number (include area code):	

SECTION TWO: BY SIGNING THIS FORM, I AUTHORIZE THE FOLLOWING:

A. Disclosures of the patient's PHI by phone or in person to the following family members or other individuals:

1. Name of family member or individual	Relationship	Date of Birth	Password
2. Name of family member or individual	Relationship	Date of Birth	Password

B. Disclosure of the patient's PHI **FROM:**

☐ All MCC Providers

If specific providers, list below:

1).	**3).**
2).	**4).**

C. Disclosure of the patient's PHI **TO:**

☐ Patient *(for personal use)*

Name of person, provider, or other third party		
Street Address		
City	State	Zip Code
Attn:	Telephone Number (include area code)	

SECTION THREE: THE PURPOSE OF THE DISCLOSURE IS:

☐ Treatment	☐ Payment	☐ MCC Operations

☐ Other (please describe):

DESCRIPTION OF INFORMATION TO BE USED OR DISCLOSED

Is this request for Mental Health, Sexually Transmissible Disease(s), Substance Abuse, and/or Genetic Testing records?

☐**Yes** This is the only item you may request on this authorization. You must submit another authorization for other items listed below**.**

☐**No** You may check as may items below as needed.

Type of Record	Date of Record(s)	Type of Record	Date of Record(s)	Type of Record	Date of Record(s)	Type of Record	Date of Record(s)
☐All PHI; or		☐IV Therapy		☐Radiology		☐Psychological Testing	
☐Progress Notes		☐Orders		☐Lab		☐Non-MCC records	
☐Operative Report		☐Neurodiagnostic		☐Billing			
☐Physical Therapy		☐Sleep Study		☐Mental Health			

X I acknowledge that the records requested above may contain alcohol, drug abuse, mental health, sexually transmissible (including HIV and AIDS) and genetic information and hereby consent to the disclosure of said information. I**nitials of Patient or Legal Representative: ____________.**

- I understand that by federal law Medical Center Clinic (MCC) may not use or disclose PHI without authorization except as provided in MCC's Privacy Practices. By signing this Authorization, I am giving permission for the uses and disclosures of the described PHI. I hereby release MCC and its employees from any and all liability that may arise from the release of information as I have directed.
- I understand that I have the right to revoke this Authorization at any time, if I do so in writing, and address it to the person or institution named above. I understand that the revocation will not apply to any actions already taken as a result of this authorization.
- I understand that I may refuse to sign this Authorization, and that MCC and/or the providers named above cannot deny or refuse to provide treatment if I refuse to sign.
- I understand that information disclosed pursuant to this Authorization may no longer be protected by the federal medical privacy law and could be disclosed by the person or agency that receives it.
- I understand that I may be charged a fee of up to $1.00 per page (plus applicable tax and handling) for every page copied and that this fee is within the limits allowed by Florida law.

This authorization expires automatically one (1) year from the date signed, if no other date or event is specified.	Expiration Date or Event: mm/dd/yyyy	
This authorization may be used to disclose PHI of the same type described above which may be created in the future until the expiration date.	☐ YES	☐ NO

SECTION FOUR: I HAVE READ AND UNDERSTAND THE INFORMATION IN THIS AUTHORIZATION FORM.

X Signature of Patient or Legal Representative	Date of Signature

FOR RELEASE OF INFORMATION USE ONLY

Request Completed By:	Total Page Count:	Amount Due $___ ___ ___.___ ___

Revised October 2011