Prestige HEALTH CHOICE®

MEDICAL RECORDS RELEASE FORM - 1of 2

(Patient access of medical information)

M.R. # _____

PATIENT NAME _____

DATE OF BIRTH _____ S.S. #_____

ADDRESS/STREET/APT_____

CITY, STATE, ZIP CODE _____ TELEPHONE #_____

I hereby authorize the Medical Records Department staff at to release information from my medical record to: (If self please indicate below)

NAME_____

ADDRESS/STREET/APT_____

CITY, STATE, ZIP CODE _____ TELEPHONE #_____

For the purpose of: (please check one)

☐ Continued Treatment ☐ Legal Review ☐ Insurance purpose ☐ Personal review of information

☐ Other (please specify) _____

I limit the information to be released to the following items: (Please check specific items)

☐ Discharge Summary ☐ Consultation ☐ Pathology Report ☐ Operative Note

☐ Emergency Department Record ☐ Other (please specify) _____

☐ Diagnostic test (e.g. Lab, X-ray, Radiology)(please specify) _____

☐ Outpatient Record (please specify) _____

Covering records from on or about (Date)_____ to (Date)_____

If the requested portion of the record contains information pertaining to mental health or drug or alcohol treatment or contains HIV related information, you must specifically authorize the release of such information by initialing one or both of the following:

- ☐ I understand that if my record contains information concerning mental health and/or drug and alcohol treatment, such information will be released pursuant to this authorization.
- ☐ I understand that if my record contains confidential HIV related information, such information will be released pursuant to this authorization form. Confidential HIV related information is any information indicating that a person had an HIV related test, or has HIV infection, HIV related illness or AIDS, or any information which could indicate that a person has been potentially exposed to HIV.

I know I do not have to allow release of HIV related information and that I can change my mind at anytime before it is released. If I experience discrimination because of release of HIV confidential information, I can call the Florida Agency for Health Care Administration at (850) 488-3849 and/or the United States Department of Health and Human Services at 1-800-368-1019 or at www.hhs.gov/ocr.

This authorization will automatically expire within six months from the date of signature.

I understand that I have a 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 medical records. I understand that the revocation will not apply to information that has already been released in response to this authorization.

I understand that Prestige Health Choice may release medical information to the federal and state governments or their duly appointed agents as required.

I also understand that I have the right to refuse to sign this authorization. Your health care, the payment for your heath care, and your health care benefits will not be affected if you do not sign this form. You also have a right to receive a copy of this form after you have signed it.

I also understand that in an effort to prevent unauthorized re-disclosure provider may attach a notice when sending out records that states, "re-disclosure is prohibited". However, the potential for an unauthorized re-disclosure may not be protected by federal confidentiality rules.

I also understand that in order to process this request to reproduce medical record information on a timely basis, in which I am requesting information from, may utilize a photocopy service and my signature authorizes the release of information to such photocopy service for the purpose of satisfying this request.

_____

Signature of Patient/ Representative/ or Legal Guardian) (Date)

_____

(If other than patient, relationship to patient) (Notary/ Witness)