FLORIDA HOSPITAL
MEMORIAL MEDICAL CENTER
HealthCare Partners

RELEASE OF INFORMATION AUTHORIZATION

Patient Name: _____ Date of Birth: _____ MR#: _____
Address: _____ Phone #: _____ SS#: _____
City: _____ State: _____ Zip Code: _____

To be completed by requester: ☐ Pick Up ☐ Mail ☐ Other: _____
If requested health information is needed for a doctor's appointment please specify date: _____

The following individual or organization is authorized to make the following disclosure:
Name: Julie D. Schneider, M.D., FACOG, FPMRS Phone: 386-231-6172
Address: 335 Clyde Morris Blvd, Suite 240 Fax: 386-676-6173
City: Ormond Beach State: FL Zip Code: 32174

Visit Date(s): _____

Forward to Health Information Management (Medical Records) for:
☐ Discharge Summary ☐ Operative Report ☐ Urgent Care Note ☐ Progress Note
☐ Pathology Report ☐ History & Physical ☐ Laboratory Report ☐ Radiology Report
☐ Assessment Note ☐ Other (specify) _____

Forward to Patient Business Office for: ☐ Billing Information

Reason for requesting information: _____
Requests may be subject to copying fee

This information may be disclosed to and used by the following individual or organization:
Name: _____ Phone: _____
Address: _____ Fax: _____
City: _____ State: _____ Zip Code: _____

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 Physician's Office Manager. 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 (not to exceed 90 days): _____. If I fail to specify an expiration date, event or condition, this authorization will expire 90 days from the date signed**.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by Federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure.

I understand the information in my health record may include psychiatric, alcohol or drug abuse/testing information which may be protected by Federal and State Regulations. I also understand that my health record may include information relating to AIDS, HIV, and/or sexually transmitted disease.

Patient Signature: _____ Date: _____

Authorized Representative/Parent: _____ Date: _____
Printed Name of Authorized Representative/Parent: _____
Relationship to Patient: _____
Address and Phone # of Authorized Representative/Parent: _____

AUTHORIZATION FOR USE AND/OR DISCLOSURE AND REQUEST FOR ACCESS TO PROTECTED HEALTH INFORMATION

PATIENT ID LABEL

Florida Hospital Memorial Medical Center
☐ HealthCare Partners
rev. 11/6/2013

IHRLSINFO