Authorization for Release of Medical Information From Ascension Sacred Heart (page 1)

Patient's Name:_____
Last First Middle

Address: _____ _____ _____ _____
City State Zip

Date of Birth: _____ Social Security No.: _____ Telephone Number: _____

I hereby authorize and request ASCENSION SACRED HEART (Releasor) to release a copy of the following medical records to:

☐ Patient Named Above

_____
Name (Releasee)

_____
Address

_____
City State Zip Telephone

Medical Records should be released in ☐ electronic or ☐ paper format.

Email Address: _____

REQUIRED

The purpose of the request for the Medical Records is:

☐ **At the request of the patient.**

☐ **Other. Explain:** _____

_____

NOTE: If you fail to specify which records you desire, you will only receive a copy of the discharge summary. A copy of the medical records ("Protected Health Information") of the above named patient pertaining to: (Check appropriate box and list the date)

☐ ASCENSION SACRED HEART PENSACOLA
☐ ASCENSION SACRED HEART EMERALD COAST
☐ ASCENSION SACRED HEART GULF
☐ ASCENSION SACRED HEART BAY
☐ Emergency Care, Date: _____
☐ Hospitalization, Date: _____ to _____
☐ Outpatient Care, Date: _____
☐ Ascension Medical Group Sacred Heart, Dates: _____
☐ Physician: _____
☐ Other: _____
_____

SPECIFIC REPORTS REQUESTED:

☐ History & Physical
☐ Physical Therapy Notes
☐ Discharge Summary
☐ Abstract (H&P, discharge summary, consult, OP report)
☐ Lab
☐ Occupational Therapy Notes
☐ X-Ray
☐ Operative Report
☐ Pathology
☐ Other: _____

REQUIRED: ____ **I do** ____ **I do not** authorize the release of information, including, if applicable, specific laboratory tests of HIV Infection (Human Immunodeficiency Virus, the causative agent of AIDS) or the diagnosis of Acquired Immune Deficiency Syndrome (AIDS) or AIDS related conditions, all medical records or other information regarding my treatment, hospitalization including psychological or psychiatric impairment, drug abuse and/or alcoholism, sickle cell anemia, sexually transmitted disease, or Hepatitis B or C.

Releasor, its agents and employees, are hereby authorized to obtain, inspect, and reproduce such records and/or information and are hereby relieved of any responsibility or liability that may arise from the release or reproduction of such records and/or information in accordance with this Authorization.

This Authorization will expire one (1) year from the date of my signature.

I understand that I have the right to revoke this Authorization, if the revocation is in writing except if (i) Ascension Sacred Heart has taken action in reliance upon this Authorization, or (ii) if this Authorization was given as a condition of obtaining insurance coverage, other law provides that the insurance company has the right to contest a claim under the insurance policy.

I understand that I may revoke this Authorization by providing a written revocation to the Director of Health Information, or if applicable, Manager of Health Information, Ascension Sacred Heart, 5151 North Ninth Avenue, Pensacola, Florida 32504, Ascension Sacred Heart Emerald Coast, 7800 Highway 98 West, Destin, Florida 32550, Ascension Sacred Heart Gulf, 3801 East Hwy. 98, Port St. Joe, Florida 32456, Ascension Sacred Heart Bay, 615 N. Bonita Ave., Panama City, Florida 32401.

I understand that my Protected Health Information that is used or disclosed under this Authorization may be subject to redisclosure by the recipient, and the privacy of my Protected Health Information may no longer be protected by law.

_____ _____
Signature of Patient Date

_____ _____
Authorized Representative if Patient unable to sign Date

_____ _____
Description of Authorized Representative's Authority to Sign for Patient Witness

PC > Consents & Legal > Information Release
EC and GC > Consents & Legal > General Consents
BAY > Admit Forms


ROI

Ascension Sacred Heart