Cleveland Health Center

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

1. Patient Information:		
Name *(First, Middle, Last)*		Cleveland Health Center Medical Record #
Current Address		City State Zip
Last 4 Digits Social Security#	Email	Phone Number ( ) Date of Birth / /

2. Release Information From (check all that apply):

☑ Cleveland Health Center (all locations): _____

3. Release Information To:

Name of Recipient		
Address	City/State	Zip
Phone Number: ( )	Fax Number: ( )	

Check delivery option desired:

☐ Paper ☐ Secure electronic delivery (provide recipient's email/portal)_____

Purpose for Disclosure: _____

(Purpose for disclosure must be completed prior to processing, e.g. continuing care, personal use, legal)

Dates of Service to Release (FROM):_____**(TO):**_____

☐ Abstract [*a summary of your visit that contains pertinent information about your treatment such as discharge summary, history and physical, consultations, operative reports, lab results, diagnostic results, and reports.]

☐ Office Visits	☐ Operative Reports	☐ Radiology Reports	☐ Physical/Occupational Therapy Reports
☐ Emergency Department	☐ History & Physical	☐ Consultation	☐ Discharge Medication List
☐ Reports	☐ Face sheet	☐ Entire Medical Record	☐ Other: _____
☐ Discharge Summary	☐ Laboratory Reports	☐ Radiation Oncology Records	

I, the undersigned, authorize Cleveland Health Center to release health information as indicated/described above. I understand and acknowledge that, unless indicated below, the requested health information may contain information regarding physical and mental illness, STI test results or diagnosis, HIV test results or diagnosis, treatment of AIDS/AIDS- related conditions, and/or alcohol/drug abuse. **This authorization does not include permission to release outpatient Psychotherapy Notes (***Psychotherapy Notes are defined as notes that document private, joint, group, or family counseling sessions that are separated from the rest of a patient's medical records.)* **Release of Psychotherapy Notes requires a separate authorization.**

I do not authorize Cleveland Health Center to release health information regarding:

☐ Mental Illness ☐ STI test results or diagnosis ☐ HIV test results or diagnosis ☐ Treatment of AIDS/AIDS related conditions ☐ Treatment related to alcohol/drug abuse

This authorization and consent will expire one year from the date of authorization written below, unless revoked by me (or my legal representative) through written notice presented to Medical Records Department (see contact information below). Any revocation will not apply to information that has already been released in response to this authorization. I understand that treatment, payment, enrollment, or eligibility for benefits will not be based on whether or not I sign this authorization.

After my health information is released, my information may be re-disclosed by the recipient and may no longer be protected by law. The recipient of my health information may be charged for the service of releasing medical information. There is no charge to send records directly to my health care provider.

If Authorization is not complete, signed and dated, it may be returned and result in my information not being released until completed.

_____ | _____ _____

*Signature of Patient/Patient's Personal Representative*** *Printed Name* *Date Signed*

_____

Relationship, if not Patient

If other than the patient's signature, a copy of legal paperwork verifying the patient's personal representative* ***MUST *accompany the request (e.g., court appointed guardian, power of attorney). Exception: parent signing for a patient under the age of eighteen.*

***For a deceased patient, a court entry or order appointing a fiduciary, executor, or administrator, or letters of appointment received from Probate Court must accompany an authorization signed by the named individual. If the estate has not been probated, a death certificate is required to be submitted with the documents naming the administrator or executor of the estate.*

Submit request to one of the following:

Cleveland Health Center
Medical Records Department
5463 Spencer Court, Wildwood, FL 34785
(352)353-0092 / (352)353-0416 (fax)

Cleveland Health Center
Medical Records Department
1050 Old Camp Rd, Ste 206, The Villages, FL 32162
(352)353-0092 / (352)353-0416 (fax)