Request for Access and Authorization for Use and/or Disclosure of Protected Health Information

Please allow a minimum of seven (7) business days to process your request.

I understand that the protected health information specified below may include mental health, substance abuse (e.g., drugs, alcohol) HIV/AIDS status information, diagnostic and treatment records.

I have read and understand the following statements:

1. I understand AdventHealth Orlando may be allowed by law to refuse to allow access to or disclosure of all or part of my protected health information. If access or disclosure is denied or refused, AdventHealth Orlando will not release the information as requested in this Authorization, and I will be notified of the denial/refusal in writing.
2. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I understand that AdventHealth Orlando will not condition treatment, payment, enrollment in any health plans or my eligibility for benefits if I decide not to sign this form.
3. I understand that I may revoke this Authorization at any time by notifying AdventHealth Orlando in writing, but if I do, it will not have any effect on any actions AdventHealth Orlando took before it received the revocation.
4. I understand that there is potential for information disclosed based on this authorization to be subject to re-disclosure by the recipient and no longer be protected by the Privacy Rule.
5. I understand that I may see and copy the information described on this form if I ask for it. I may receive a copy of this form after I sign it if the request for disclosure was initiated by AdventHealth Orlando.
6. I understand this Authorization will expire on _____/_____/_____ or when the following event occurs: _____.
   If no expiration date, event or condition is noted this authorization will expire 1 year from the date signed.

☐ This authorization is valid for information created within 12 months after the date this authorization is signed, as well as past information.
I understand it is my responsibility to notify AdventHealth Orlando to initiate follow-up requests based upon this standing authorization.

Patient's Legal Name: _____ Date of Birth: _____

Address: _____

Patient Phone Number: _____ MRN: _____

I authorize AdventHealth Orlando to: ☐ Disclose to ☐ Obtain from _____ and send to below requestor.

Name: _____ Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

☐ Email address (via secured server) / Electronic: _____
☐ Paper (I understand that all records will be mailed unless specified)

Request access and/or disclosure of records for the following dates of service: _____ (Check appropriate boxes below)

☐ Abstract of Record (Dictated Reports, Laboratory, Cardiology, Radiology Reports) ☐ Emergency Physician Sheet ☐ Billing Records
☐ Discharge Summary ☐ Operative Report(s) ☐ History & Physical ☐ Laboratory Results ☐ Mental Health Records
☐ Pathology Reports ☐ Radiology Report(s) ☐ Radiology Image(s) ☐ OT/PT/Speech Therapy ☐ Facesheet
☐ Other: _____

Patient Signature: _____ Printed Patient Name: _____

LAP Signature: _____ Print Name: _____
(Legally Authorized Person)

Witness Signature: _____ Print Name: _____

Date: _____

Request for Access has been: ☐ Partially Denied ☐ Denied
If access is denied and patient requests review of denial, contact the Release of Information office below.

Medical Records released/accessed: Date of release/Access _____ By: _____

Send to Release of Information:
Email: CFD-S.HIM.CSC.Incoming.Faxes@AdventHealth.com
Fax: 407-303-0633 Phone: 407-303-9175
Mailing address: AdventHealth Orlando Health Information Management Release of Information
900 Winderley Place, Suite 1200 Maitland, FL 32751

You have the right to complain to the Office of Civil Rights. The following is the contact information:
Office of Civil Rights ~ U S Department of Health & Human Services 61 Forsyth Street, SW. Suite 3B70 Atlanta, GA 30323 ~ Phone# 404-562-7886; 404-331-2867

Patient Name _____
FIN _____ MRN _____
or Patient Label