

## AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

**Section A: This section must be completed for all Authorizations**

<b>Patient Name:</b>	<b>Birth Date:</b>	<b>Social Security No. (optional):</b>	
<b>Provider's/Health Plan's Name:</b> <b>Palms West Hospital</b>	<b>Recipient's Name:</b>		
<b>Provider's/Health Plan's Address:</b>  <b>13001 Southern Blvd Loxahatchee, FL 33470</b>	<b>Address 1:</b>		
	<b>Address 2:</b>		
	<b>City:</b>	<b>State:</b>	<b>Zip:</b>

This authorization will automatically expire in 60 days **OR** fill in the Date or the Event that you want it to expire (but not both).  
**Date:** \_\_\_\_\_ **Event:** \_\_\_\_\_

**Purpose of disclosure:**

**Description of information to be used or disclosed**

**Date(s) of Service:**

<input type="checkbox"/> Admission Form <input type="checkbox"/> Anesthesia/Operative Information <input type="checkbox"/> Billing Record <input type="checkbox"/> ER Information <input type="checkbox"/> Laboratory Results <input type="checkbox"/> Medication Sheets <input type="checkbox"/> Nursing Information	<input type="checkbox"/> Physician Dictation Reports <input type="checkbox"/> Physician Orders <input type="checkbox"/> Physician Progress Notes <input type="checkbox"/> Radiology Reports/Films <input type="checkbox"/> Rhythm Strips/EKG <input type="checkbox"/> Abstract of PHI in Medical Record (All test results and Physician dictated reports)	<input type="checkbox"/> All PHI in Medical Record <input type="checkbox"/> Other: _____ <input type="checkbox"/> Other: _____ <input type="checkbox"/> Other: _____
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I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. \_\_\_\_\_ (Initial)

- I understand that:
1. I may refuse to sign this authorization and that it is strictly voluntary.
  2. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.
  3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
  4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
  5. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it.
  6. I get a copy of this form after I sign it.

**Section B: Is the request of PHI for the purpose of marketing?**

If yes, the health plan or health care provider must complete Section B, otherwise skip to Section C.

Will the recipient receive financial or in-kind compensation in exchange for using or disclosing this information?  Yes  No


If yes, describe: \_\_\_\_\_

**Section C: Signatures**

I have read the above and authorize the disclosure of the protected health information as stated.

<b>Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative:</b>	<b>Date:</b>
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<b>Print Name of Patient/Plan Member's Representative:</b>	<b>Relationship to Patient/Plan Member:</b>
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 <p><b>Palms West</b> HOSPITAL 13001 Southern Blvd. Loxahatchee, FL 33470 (561) 798-3300</p> <p><small>*ROI*</small></p>	<p>PATIENT LABEL</p> <p>WHITE - CHART      CANARY - PATIENT</p>
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13001 Southern Blvd.  
Loxahatchee, FL 33470  
(561) 798-3300

\*ROI\*

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WHITE - CHART
CANARY - PATIENT