Miami Beach Community Health Center

PATIENT AUTHORIZATION FORM FOR DISCLOSURE OF HEALTH INFORMATION

PLEASE READ THE ENTIRE FORM, ALL THREE PAGES, BEFORE SIGNING BELOW

Patient (name and information of person whose health information is being disclosed):

Name (First Middle Last): _____

Date of Birth (mm/dd/yyyy): _____

Address: _____ City: _____ State: _____ Zip: _____

You may use this form to allow limited access to and use of your health information by certain persons for certain purposes. Your choice on whether to sign this form will not affect your ability to get medical treatment, payment for medical treatment, or health insurance enrollment or eligibility for benefits.

By signing this form, I voluntarily authorize, give my permission and allow use and disclosure (including paper, oral and electronic interchange):

OF WHAT: (initial one)

_____ **ALL MY HEALTH INFORMATION** including information about sensitive conditions (if any). Health information includes, but is not limited to, all records and other information regarding my health history, treatment, hospitalization, tests, and outpatient care, and also educational records that may contain information about my health. This includes my specific permission to release any and all of the following information:

a. Drug, alcohol, or substance abuse
b. Psychological, psychiatric or other mental impairment(s) or developmental disabilities (excludes "psychotherapy notes" as defined in HIPAA at 45 CFR 164.501)
c. Sickle cell anemia
d. Birth control and family planning
e. Records which may indicate the presence of a communicable disease or noncommunicable disease; and tests for or records of HIV/AIDS or sexually transmitted diseases or tuberculosis
f. Genetic (inherited) diseases or tests
g. Copies of educational tests or evaluations, including Individualized Educational Programs, assessments, psychological and speech evaluations, immunizations, recorded health information (such as height, weight), and information about injuries or treatment.

_____ **ONLY THE INFORMATION INDICATED BELOW** (initial next to all that you want disclosed):

_____ History and Physical _____ Operation Reports _____ Discharge Summary _____ Radiology Reports & Images
_____ Pathology Reports _____ EKG Reports _____ Progress Notes _____ Consultation Reports
_____ Lab Results _____ Physician's Orders _____ Drug, Alcohol or Substance Abuse Records
_____ Family Planning Records _____ Prenatal Records
_____ Mental Health Records (excluding "psychotherapy notes" as defined in HIPAA at 45 CFR 164.501)
_____ Diagnostic Test Reports (specify type of test): _____
_____ Other (please specify): _____

Note: Information created before or after the date of this form may be disclosed, unless you specify a date range of records here:

From (mm/dd/yyyy): _____ To (mm/dd/yyyy) : _____.

FROM WHOM: (choose one)

○ **Miami Beach Community Health Center**
H.I.M Department (Medical Records)
11900 Biscayne Blvd, Suite 510
North Miami, FL 33181
Phone Number: (305) 538-8835
Fax Number: (305) 994-0054

○ **Only the following specific sources of my health information**:

Person/Organization Name: _____ Phone: (____) _____
Address: _____ Fax: (____) _____
Person/Organization Name: _____ Phone: (____) _____
Address: _____ Fax: (____) _____

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TO WHOM: (check one)

- ○ **Miami Beach Community Health Center**
  H.I.M Department (Medical Records)
  11900 Biscayne Blvd, Suite 510
  North Miami, FL 33181
  Phone Number: (305) 538-8835
  Fax Number: (305) 994-0054

○ Specific person(s) or organization(s) permitted to receive my information:

Person/Organization Name: _____ Phone: (____) _____

Address: _____ Fax: (____) _____

Person/Organization Name: _____ Phone: (____) _____

Address: _____ Fax: (____) _____

PURPOSE: (check all that apply)

- ○ Continuation of care
- ○ Legal
- ○ Personal use
- ○ Other, please specify: _____

EFFECTIVE PERIOD: This authorization/permission form is valid for a (90) day period from the date it is signed or sooner if so specified by me, as indicated below.

○ A specific date (mm/dd/yyyy): _____

REVOKING YOUR PERMISSION: I can revoke my permission at any time by giving written notice to the person or organization to whom I originally gave this form.

In addition:

- I authorize the use of a copy (including electronic copy) of this form for the disclosure of the information described above.
- I understand that there are some circumstances in which this information may be redisclosed to other parties (see page 2 for details).
- Request for copies of medical records are subject to reproduction fees in accordance with federal/state regulations. F.S. 395.3025, F.S 456.057
- I understand that refusing to sign this form does not stop disclosure of my health information that is otherwise permitted by law without my specific authorization or permission.
- I have read all pages of this form and agree to the disclosures above from the types of sources listed.

X _____ _____

Signature of Patient or Patient's Legal Representative — Date Signed (mm/dd/yyyy)

_____

Print Name of Legal Representative (if applicable)

Check one to describe the relationship of Legal Representative to Patient (if applicable):

- ○ Parent of minor
- ○ Guardian
- ○ Other personal representative (explain: _____)

This form is invalid if modified. You are entitled to get a copy of this form after you sign it.

OFFICE USE ONLY

Completed Date (mm/dd/yyyy): _____ **Print Employee Name:** _____

Were copies given to patient? ☐Yes ☐ No **Employee Signature:** _____

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Further Explanation of Form "Patient Authorization Form for Disclosure of Health Information"

Laws and regulations require that some sources of personal information have a signed authorization or permission form before releasing it. Also, some laws require specific authorization for the release of information about certain conditions and from educational sources.

Definitions: In this form, the term "treatment," "healthcare operations," "psychotherapy notes," and "protected health information" are as defined in HIPAA (45 CFR 164.501).

Note on Mental Health Records: If you are requesting a copy of your mental health records with this form, Florida allows such access, unless such access is determined by your physician to be harmful to you. For more information, see Florida Statute 394.4615(10).

"To Whom":

- If you specified a healthcare provider in the "TO WHOM" section above, this permission would also include physicians, other health care providers (such as nurses) and medical staff who are involved in your medical care at that organization's facility or that person's office, and health care providers who are covering or on call for the specified person or organization, and staff members or agents (such as business associates or qualified services organizations) who carry out activities and purpose(s) permitted by this form for that organization or person that you specified.
- If you specified an organization other than a healthcare provider in the "TO WHOM" section above, this permission would also include that organization's staff or agents and subcontractors who carry out activities and purpose(s) permitted by this form for that organization that you specified.

Revocation: You have the right to revoke this authorization and withdraw your permission at any time regarding future uses by giving written notice. You should understand that organizations that had your permission to access your health information may copy or include your information in their own records. These organizations, in many circumstances, are not required to return any information that they were provided nor are they required to remove it from their own records.

Re-disclosure of Information: Any health information about you may be re-disclosed to others only to the extent permitted by state and federal laws and regulations. You understand that once your information is disclosed, it may be subject to lawful re-disclosure, in accordance with applicable state and federal law, and in some cases, may no longer be protected by federal privacy law.