



Hospice and Community Services
Licensed by the State of Florida Since 1984

9470 HealthPark Circle
Fort Myers, FL 33908
(239) 482-4673 • Fax (239) 482-7897

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

I hereby authorize _____ to disclose the following information from the health records of:
(Name of Provider)

Patient Name _____
Address _____

Date of Birth _____
Telephone _____
SS# _____

SEND INFORMATION TO: (please be specific)

Provider Name/Organization: _____

Address: _____

Phone #: _____ Fax #: _____

INFORMATION TO BE RELEASED FROM: (please be specific)

Provider Name/Organization: _____

Address: _____

Phone #: _____ Fax #: _____

PURPOSE OF DISCLOSURE: Transfer of Care Self Specialist Other _____ (must complete)

Covering the following period(s) of healthcare:

From (date) _____ to (date) _____

From (date) _____ to (date) _____

INFORMATION TO BE DISCLOSED:

- | | |
|---|---|
| <input type="checkbox"/> History and Physical Exam | <input type="checkbox"/> Discharge Summary |
| <input type="checkbox"/> Progress Notes | <input type="checkbox"/> Consultation Reports |
| <input type="checkbox"/> X-Ray Reports | <input type="checkbox"/> Laboratory Tests |
| <input type="checkbox"/> Complete Designated Record Set | |
| <input type="checkbox"/> Other (please specify) _____ | |

I understand I have the right to inspect and/or request a copy of the information to be disclosed and I may withdraw this authorization in writing at any time, except to the extent that action has been taken based on this authorization. I understand this authorization shall expire, without my expressed revocation, six (6) months from the date of signature. I am aware that once this information has been disclosed per my instructions the information is subject to re-disclosure and may no longer be protected by the Federal Privacy Law of 1996 (HIPAA). If the patient is unable to sign, please indicate such and the authority to act of the person who is signing for the patient.

The facility, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized here in.

Date Signature of Patient or Representative Relationship to Patient

DISCLOSURES REQUIRING SPECIAL CONSENT:

My signature below specifically authorizes the release of healthcare information relating to the testing, diagnosis, or treatment for: HIV/AIDS Virus Mental Health/Psychiatric Disorders Sexually Transmitted Diseases Drug, Alcohol Abuse/Treatment

Date Signature of Patient or Representative Relationship to Patient