SOUTHERN WINDS HOSPITAL

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Print Name of Patient (First, Middle, Last) _____ Health Record Number _____

Previous Name, if Applicable _____ Date of Birth _____

Daytime Telephone Number _____ Dates of service requested _____

INFORMATION MAY BE DISCLOSED BY:

Name/Organization: Southern Winds Hospital

Address: 4225 West 20th Avenue, Hialeah, Florida 33012

Phone #: 786-828-7552 Fax #: 305-557-1650

INFORMATION MAY BE DISCLOSED TO:

Name/Organization: _____

Address: _____

Phone #: _____ Fax #: _____

INFORMATION TO BE DISCLOSED:

- ☐ Discharge summary
- ☐ History, physical
- ☐ Labs
- ☐ Consultations
- ☐ Treatment plan/summary
- ☐ Medication
- ☐ Psychiatric evaluation
- ☐ Psychological evaluation
- ☐ EKG
- ☐ X-Rays
- ☐ Other: _____
- ☐ Abstract (includes face sheet, psychiatric evaluation, discharge summary, consultations, and history & physical evaluation)

PURPOSE OF DISCLOSURE:

- ☐ Use by another health care provider
- ☐ Personal copy
- ☐ Continuity of care
- ☐ Attorney request
- ☐ Other: (*please describe*) _____

RESTRICTION ON DISCLOSURE: _____

EXPIRATION DATE: This authorization will expire in thirty (30) days from the date on which it was signed.

REDISCLOSURE: I understand that once the above information is disclosed, it may be redisclosed by the recipient and the information may not be protected by federal privacy laws or regulations. The facility named above is released from all legal liability that may arise from the release of the information requested.

CONDITIONING: I understand that completing this authorization form is voluntary. I realize that the disclosing organization will not condition my treatment on completing this form.

SENSITIVE RECORDS: Unless specifically restricted by me, I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol or drug abuse. Federal regulations (42CFR, Part 2) prohibit making any further disclosure of it without the specific written authorization of the undersigned, or as otherwise permitted by such regulations.

REVOKING THE AUTHORIZATION: I understand that I have the right to revoke this authorization any time. If I revoke this authorization, I understand that I must do so in writing and present my written revocation to the Health Information Management Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

Date _____ Signature of Patient or Legal Representative _____ Relationship to Patient _____

Date _____ Witness _____