

**Record Request: Authorization to Use and Disclose Protected Health Information (“PHI”) Maintained by UF Health\***

*\*For purposes of this agreement, UF Health describes a collaboration of the University of Florida Board of Trustees for the benefit of the University of Florida College of Medicine, Shands Jacksonville Medical Center, Inc., Shands Teaching Hospital and Clinics, Inc., and Shands Recovery, LLC. Collectively, these entities are referred to as UF Health in this form.*

Patient's Name	Date of Birth	Medical Record #	Verification of Identity <input type="checkbox"/> Driver License/State ID <input type="checkbox"/> Personally known <input type="checkbox"/> Other:
Patient's Address	City	State	Zip
Phone #	Last 4 digits of SSN (Optional)		<input type="checkbox"/> Check if patient is an employee of UF Health Shands

**Complete the section below only if the person requesting records is not the patient:**

Name of Representative	Relationship to Patient	Legal Authority
Representative's Address & Phone Number	Verification of Identity	Verification of Authority

**By signing this form, I authorize the release of PHI (i.e., medical records) as follows:**

**From the doctor, office, facility of other health care provider checked or written below:**

<input type="checkbox"/> University of Florida person, class of persons, or organization:  Clinic, person, class of persons, or organization  Address  Phone Attn	<input type="checkbox"/> <b>UF Health Shands Hospital</b> ▪ PO Box 100345, Gainesville, FL 32610-0345 Phone: 352.265.0131 ▪ Fax: 352.265.1098 <input type="checkbox"/> <b>UF Health Shands Rehab Hospital</b> ▪ 4101 NW 89th Boulevard, Gainesville, FL 32606 Phone: 352.265.5491 ▪ Fax: 352.627.4425 <input type="checkbox"/> <b>UF Health Shands Psychiatric Hospital</b> ▪ 4101 NW 89th Boulevard, Gainesville, FL 32606 Phone: 352.265.5497 ▪ Fax: 352.627.4425 <input type="checkbox"/> <b>UF Health Florida Recovery Center</b> ▪ 4001 SW 13th Street, Gainesville, FL 32608 Phone: 352.265.5500 ▪ Fax: 352.265.5504 <input type="checkbox"/> <b>UF Health Shands HomeCare</b> ▪ 3515 NW 98th Street, Gainesville, FL 32606 Phone: 352.265.0789 ▪ Fax: 352.265.9276
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**To the facility / person below:**

Clinic, person, class of persons, or organization	Address and Fax Number	<input type="checkbox"/> Check here if same as patient <input type="checkbox"/> Check here for records pick-up only
Attn:		

<b>The following PHI may be released (describe in detail or use the check boxes below):</b>			<b>I further authorize the release of the following information which may be included in the PHI:</b>
<input type="checkbox"/> History and Physical	<input type="checkbox"/> Operative Reports(s)	<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> Mental Health/Psychiatric Treatment
<input type="checkbox"/> Problem List	<input type="checkbox"/> Medication List	<input type="checkbox"/> Treatment Notes	<input type="checkbox"/> Alcohol or Substance Abuse Treatment
<input type="checkbox"/> Emergency Room Record	<input type="checkbox"/> Radiology Reports/Films	<input type="checkbox"/> Lab/Pathology Reports	<input type="checkbox"/> STD/HIV/AIDS Treatment(s) or Test(s)
			<input type="checkbox"/> Genetic Testing
<b>Is this needed for a doctor's appointment?</b>	Write date below:	<b>Are there specific dates needed?</b>	Write dates below:

<b>Purpose of this request?</b>	<input type="checkbox"/> Treatment/Continued Care <input type="checkbox"/> Payment/Billing <input type="checkbox"/> Personal Use <input type="checkbox"/> Other:
<b>Format of Records?</b>	<input type="checkbox"/> Through a web portal, with notice provided to my e-mail account at: _____ To request records in electronic PDF form, please check the box above and provide a valid and clear e-mail address. You will receive an e-mail from HealthPort and that e-mail will tell you how to get the records. <input type="checkbox"/> Paper

This authorization allows UF Health to use and disclose (release) certain PHI, which includes medical records, as I have directed.

- I understand that:
- The PHI may include information about mental health, substance and/or alcohol abuse, HIV/AIDS, and STDs.
  - This authorization may be used to share the same type of PHI indicated above which may be created in the future, until the expiration date.
  - This authorization will remain in effect for one (1) year or until I revoke it in writing (i.e., tell UF Health to cancel it).
  - I have the right to revoke this authorization at any time, if I do so in writing to the Health Information Management Department at the organization named above and that the revocation will not apply to action already taken as a result of this authorization.
  - I may refuse to sign this authorization and doing so will not affect my treatment, payment, enrollment, or eligibility for benefits or the quality of care that I will receive.
  - I understand that PHI released per this authorization may no longer be protected by state law or the federal health privacy law and could be re-disclosed by the person or entity that receives it.
  - I am aware that I may be charged a fee for this request as allowed by law, which may include up to \$1.00 per page (plus applicable tax and handling) for Paper Records and fees associated with labor, supplies (i.e. cost of a computer disk), and postage for Electronic Records. Fees are waived when PHI is released to a health care provider for treatment purposes.

**Signature of patient / patient representative \_\_\_\_\_ Date \_\_\_\_\_**

