ORLANDO HEALTH®

Mailing Address: 1414 Kuhl Ave. • Orlando, FL 32806

LINE UP PATIENT I.D. LABEL HERE

AUTHORIZATION TO OBTAIN, RELEASE, OR REVIEW PROTECTED HEALTH INFORMATION

I. PATIENT AND REQUESTOR INFORMATION

Patient Name:_____ Date of Birth _____ / _____ / _____

Address:_____ Social Security # (last 4 digits) _____

_____ Email:_____

Requestor Name: _____ Telephone #: _____

II. PERSON/FACILITY AUTHORIZED TO RELEASE THE PROTECTED HEALTH INFORMATION:

Name: _____

Address: _____

Phone: _____

Fax: _____

III. PERSON/FACILITY AUTHORIZED TO OBTAIN THE PROTECTED HEALTH INFORMATION:

Name:_____ Phone: _____

Address/ Email:_____

Fax Number:_____

For Family Management Account Only: Date of Birth: ____/____/_____ Relationship to Patient: _____

IV. RECORDS REQUESTED AND METHOD OF DELIVERY

Format of Records: ❑ Paper ❑ Electronic (E-Mail ☐ / CD☐ - Please Circle) ❑ Patient Portal

Method of Delivery: ❑ Mail ❑ E-Mail ❑ Pick-Up ❑ Fax (Medical Facilities Only)

Purpose of Disclosure: ❑ Personal Use ❑ Continued Treatment ❑ Insurance ❑ Legal ❑ School ❑ Family and Medical Leave Act/Disability Forms ❑ Patient Communication (Behavioral Health) ❑ Other (Please Specify): _____

Date Range of Records Requested: _____ to _____ **-OR-** ❑ **COMPLETE RECORD (All Records, All Dates)**

Type of Records: ❑ Abstract of Record ❑ Lab ❑ Pathology ❑ Radiology (CD) ❑ Radiology (Report) ❑ Therapy Records ❑ Progress Notes ❑ Consultation ❑ Operative ❑ All Diagnostic Test Results ❑ Other (Please Specify): _____

May NOT include information related to (please initial):

_____ HIV/AIDS _____ Mental Health _____ Drug and/or Alcohol Abuse _____ Genetic Counseling/Testing Information

I understand that this authorization extends to all or any part of the records designated above, which may include psychiatric information, and/or genetic counseling/testing, and/or alcohol/drug abuse, and/or AIDS (Acquired Immunodeficiency Syndrome), and/or may include the result of an HIV test or the fact that an HIV test was performed. I expressly consent to the release of information as designated above unless initialed above or otherwise required by law.

The authorization will expire on the following date, event or condition: _____. If I fail to specify an expiration event or condition, the authorization will expire in one year. I understand that this authorization is revocable upon written notice to the office where the original authorization is retained, except to the extent that action has already been taken on this authorization. I understand that my protected health information that is used or disclosed under this authorization may be subject to re-disclosure by the recipient and the privacy of my protected health information may no longer be protected by law. I further understand that Orlando Health may not condition the provision of treatment, payment, enrollment in the health plan, or eligibility for benefits on the provision of this authorization. Patient Portal Proxy authorization will remain active until revoked. I understand that I will receive a signed copy of this form.

_____ _____ _____

Patient / Legal Guardian Signature Date Time

❑ I wish to revoke this authorization. Signature:_____ Date:_____ Time:_____

OFFICIAL USE ONLY:

Name_____Date:_____ ❑ Releasing Information

Number of Pages Copied: _____ ID Shown_____ ❑ Assisting with Review

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Instructions to Obtain, Release, or Review Protected Health Information or to have access to the Patient Portal.

Important:

1. Please read all instructions and information before completing and signing the form.
2. **Fees:** Release of records directly to the patient or authorized representative may result in a fee per page. There is no charge to release records for continuity of care (provider to provider)
3. **Incomplete Forms:** May result in processing delays if required information is not completed on form. Incomplete forms may not be accepted.

Instructions:

The following information will help you with filling out the required sections on the form. Please type or print as clearly and completely as possible.

- **Section I:** Fill in the patient's information and requestor's name and contact number.
- **Section II:** Fill in the person, provider, or facility that is responsible to release the medical records.
- **Section III:** Fill in the person or facility name where the records being released should be sent to.
  - **Family Management Account:** If providing care to a family member or person you are responsible for, a Family Management Account authorizes a person to interact with the patient's FollowMyHealth account.
    - Please list the **Date of Birth** and **Relation to Patient** of the person who is receiving access to the patient's portal account.
- **Section IV:** Options for format of records, delivery method (pick-up, mail, e-mail, fax), purpose of disclosure, date range of records, and type of records.

Family Management Account - Additional Information

- **Minor authorized individual (0-10 years old):** This access level is always **Full Access**. Access enables parent or legal guardian to have access to child's medical information.
- **Young adult authorized individual (11-17 years old):** This access is restricted for any level. Once child transitions to young adult age, health record updates will no longer be entered into the child's FollowMyHealth account.
- **Adult authorized individual (18 years & older):** This access enables spouses, adult children, & others to have access to an adults patient's account. This can be **Full Access** or **Read Only** as directed by the person authorizing access.
- **Full Access:** Full functionality of the patient account.
- **Read Only:** Authorized individual can only view patient account, but cannot make any changes on the patient behalf or use messaging component of the portal.

Questions?

For Orlando Health: Physician Practices: (321) 841-3064

For Orlando Health: Hospital Facilities: (321) 841-5450

For information on our website: www.orlandohealth.com/medicalrecords

OFFICIAL USE ONLY: IN-HOUSE COPIES

Name of Team Member delivering Records to Patient:_____

Patient Signature:_____ Date:_____ Time:_____

COMMUNICATION ASSISTANCE PROVIDED (Please Print)		
QUALIFIED INTERPRETER	**QUALIFIED BILINGUAL TEAM MEMBER**	**ASSISTING VISUALLY IMPAIRED**
Team Member Name & I.D.: _____	Team Member Name & I.D.:	Team Member/Reader Name & I.D.:
Agency/Interpreter Name and/or I.D.: _____	_____	_____
☐ Video remote ☐ Tel ☐ In-person Language: _____	Language: _____	Other: _____