ORLANDO HEALTH®

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

LINE UP PATIENT I.D. LABEL HERE

PATIENT REQUEST FOR PROTECTED HEALTH INFORMATION (MEDICAL RECORDS)

PATIENT INFORMATION:

First Name:	Middle Initial:	Last Name:

Date of Birth:	Phone:	E-Mail:

Address:	City:	State:	Zip:

WHERE ARE YOU REQUESTING RECORDS FROM?

HOSPITAL (check appropriate boxes)

- ☐ Arnold Palmer Hospital
- ☐ Bayfront Health
- ☐ Dr. P. Phillips Hospital
- ☐ Health Central Hospital
- ☐ Horizon West Hospital
- ☐ Orlando Regional Medical Center
- ☐ South Lake Hospital
- ☐ South Seminole Hospital
- ☐ St. Cloud Hospital
- ☐ Winnie Palmer Hospital

PHYSICIAN PRACTICE (write in information)

Practice / Provider Name:

Address:

Phone/Fax:

Other (write in Orlando Health facility name & address):

WHO DO YOU WANT THE RECORDS SENT TO?

Orlando Health should provide my records to: ☐ **Self** -OR- ☐ **Personal Representative** -OR- ☐ **Third Party** (indicated below)

Recipient Name (if other than self):	**Phone:**
	Fax (Medical Facilities only):

Recipient Mailing or E-Mail Address:

WHAT RECORDS ARE YOU REQUESTING?

Date(s) of Service: ________/________/________ through ________/________/________

- ☐ Abstract (All Notes & Diagnostic Results)
- ☐ Consultation Notes
- ☐ Discharge Summary
- ☐ Emergency Room Notes
- ☐ History and Physical Notes
- ☐ Progress Notes
- ☐ Operative/Procedure Notes
- ☐ Therapy Notes
- ☐ Lab Results
- ☐ Pathology Results
- ☐ Radiology Report (CT, MRI, X-Ray, etc)
- ☐ Radiology Images (DICOM - CD/DVD)

☐ Other (please specify): ______________________________

I understand that the protected health information specified above may include mental health, substance abuse (e.g., drugs, alcohol) HIV/AIDS status information, diagnostic and treatment records.

HOW DO YOU WANT THE RECORDS TO BE DELIVERED?

Electronic Delivery:
- ☐ MyChart (Patient Portal)
- ☐ Secure E-Mail (encrypted, size limits)
- ☐ Fax (Medical Facilities only)

Mail Delivery:
- ☐ Paper (fees may apply)
- ☐ Electronic (CD/DVD)

In Person Pick-Up:
- ☐ Paper (fees may apply)
- ☐ Electronic (CD/DVD)

Walk-in locations listed at: www.orlandohealth.com/medicalrecords

PLEASE PRINT YOUR NAME AND SIGN BELOW

Name of Patient or Guardian/Personal Representative (please print):	**Relationship to Patient** (please print):	
Signature of Patient or Guardian/Personal Representative:	**Date/Time:**	**Expiration Date** (optional):

SUBMIT COMPLETED FORM TO:

Mail: 3090 Caruso Ct, Suite 50 MP69, Orlando, FL 32806
Drop off locations listed at www.orlandohealth.com/medicalrecords

Fax: (321) 843-6411
E-Mail: medicalrecords@orlandohealth.com

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EXPLANATION OF FORM

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.

By signing this form:

- You 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. You have expressly consented to the release of this information as designated above or otherwise as required by law.
- You understand that the authorization will expire on the date specified in the Expiration Date. If you fail to specify an expiration event or condition, the authorization will expire in one year from the date signed.
- You 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.
- You understand that your protected health information that is used or disclosed under this authorization may be subject to re-disclosure by the recipient and the privacy of your protected health information may no longer be protected by law.
- You 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.
- You understand that you will receive a signed copy of this form if requested.
- You understand that there may be fees charged for providing you with a copy of your medical records as permitted by Florida Law. Fees are listed on our website, walk-in medical record locations, or by calling our department.

Health Information Management – Release of Information
Web Site: www.orlandohealth.com/medicalrecords
Phone: (321) 841-4449

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