

Authorization for Release of Medical Record Information

I hereby authorize Lee Memorial Health System to release my protected information including information from my medical record including HIV (AIDS) testing, sexually transmitted disease, mental health and/or substance abuse services. I further release Lee Memorial Health System from all legal responsibility and/or liability that may arise from the release of such records as specified above and I hereby waive all rights I have to preserve their confidentiality.

Patient's Legal Name: _____ Date of Birth: _____

Telephone: (_____) _____

Mail to: Name _____

Address: _____ City: _____ State: _____ Zip: _____

The information is to be: Mailed Picked-up – Date: _____ Time: _____ AM PM

The request is subject to the limitations as listed below and is for the purpose of:

Personal Payment Healthcare Operations Other: _____

Treatment (Continued Care) Physician Appointment (Date/Time): _____

Please furnish the following:

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> Emergency Dept. Notes | <input type="checkbox"/> Consultation | <input type="checkbox"/> Physician Office Notes | <input type="checkbox"/> Immunizations |
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Physician Orders | <input type="checkbox"/> Operative Record | <input type="checkbox"/> HIV Results (AIDS Testing) |
| <input type="checkbox"/> History & Physical Exam | <input type="checkbox"/> Progress Notes | <input type="checkbox"/> Pathology Report | <input type="checkbox"/> Laboratory Results |
| <input type="checkbox"/> Radiology Tests | <input type="checkbox"/> Diagnostic Tests | <input type="checkbox"/> Psychiatric/Psychological Testing (Mental Health) | |
| <input type="checkbox"/> Other: _____ | | | |

This authorization is for the listed date(s) of treatment:

From (Date): _____ To (Date): _____ Special Instructions: _____

I further agree to pay fees charged to provide the information requested.

I understand that fees are within the fee allowed by Florida Law.

Pursuant to Florida Statute 395.3025
The exclusive charge for copies of patient records may include sales tax and actual postage, and except for nonpaper records, (microfilm) which may not exceed \$1.00 per page, as provided in S.28.48(8)(A). A fee of up to \$1.00 may be charged for each year of records requested. These charges shall apply to all records furnished, whether directly from the facility or from a copy service providing these services on behalf of the facility.
However, a patient whose medical records are copied and/or searched for the sole purpose of continuing his/her medical care will not be required to pay any associated copying charges.
Patient Initials: _____

Consent to Minors
Minor's are permitted to consent to medical care and treatment in the following situations. Thus, the parents are not entitled to the minor's medical information without written consent of the minor, a valid subpoena or court order.
1. A minor who is, or has been, married.
2. An unwed pregnant minor consenting to the performance of medical or surgical care or services relating to her pregnancy.
3. An unwed minor mother consenting to the medical or surgical care or services of her child.
4. A minor seeking voluntary substance abuse impairment services.
5. A minor consenting to the examination and treatment of a sexually transmitted disease.
6. A minor receiving contraceptive information or services.
7. A minor with a court order removing the disability of nonage.
8. Unless a parent objects in writing, any minor who has reached the age of 17 years may give consent to the donation, without compensation therefore, of his blood and to the penetration of tissue which is necessary to accomplish such donation.
9. Under certain circumstances, a minor age 13 years or older may consent to outpatient crisis intervention services and treatment.

The fees are waived only if the copies are forwarded to a physician office and/or health care provider.

Patient Signature: _____ Date: _____

If the legal representative, sign below and state relationship and authority to do so and attach a copy of the document of authority.

Legal Representative: _____ Authority: _____

Custodial Parent/Guardian: _____ Date: _____

This authorization is in effect until _____ or for 1 year from date signed.

LMHS will not condition treatment, payment, enrollment in a health plan, or eligibility for benefits on the individual providing authorization of the requested use as stated above. This authorization may be revoked except to the extent that action(s) have been taken as outlined by this authorization; the revocation must be in writing according to LMHS policy and procedures outlined in our Statement of Privacy Notice. Information used/disclosed pursuant to the authorization may be subject to redisclosure by the recipient and no longer protected by Federal Privacy Rules.