

AUTHORIZATION FOR RELEASE OF PATIENT MEDICAL INFORMATION

I, _____ date of birth ____/____/____, SSN _____/____/____
hereby request and authorize (check appropriate box)

| | |
|------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> UNIVERSITY COMMUNITY HOSPITAL 3100 East Fletcher Avenue, Tampa, FL 33613 | <input type="checkbox"/> UNIVERSITY COMMUNITY HOSPITAL - CARROLLWOOD 7171 N. Dale Mabry Highway, Tampa, FL 33614 |
|------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------|

Other _____
(Name and address of provider releasing records)

To release my PHI (Protected Health Information) specified:

- All general medical records, or
- Limited records (specify by type of record or by date of service):
- Including HIV/AIDS records (if applicable)
- Including Psychiatric/Psychological Records (if applicable)
- Including treatment of Drug or Alcohol Abuse

For the purpose of:

- Continuing to receive medical care
- Information for the insurance company
- Information for attorney
- Personal use, by and at the request of the patient or their legal representative
- Other (specify) _____

These records to be provided to:

Name of person or agency information is authorized to be disclosed to: _____

Address _____

City _____ State _____ Zip _____ (Telephone/Fax number) _____

Authorized By:

Date signed _____ Signature of patient or legal representative* _____

*If you are signing as the patient's representative, please print your name _____, and describe why you have the legal authority to represent the patient (for example: spouse, child, durable power of attorney for healthcare, etc.):

***Note:** If your authority to act as the patient's representative comes from a document (for example: a durable power of attorney for healthcare, appointment of healthcare surrogate, appropriate estate documents or a custody decree), a copy of the document must accompany this authorization.

This authorization will expire automatically 90 days after the date signed. You may revoke this authorization at any time by notifying UCH, Inc. in writing to the Medical Records Department at the address of the hospital checked above of your intent to revoke this authorization. The written revocation will not affect any information already disclosed by UCH prior to revocation.

NOTE TO THE RECIPIENT OF THE ATTACHED RECORDS PROHIBITION ON REDISCLOSURE

This information has been disclosed to you from records whose confidentiality is protected by state and federal laws. Unless this is your health information, state and federal laws prohibit you from making any further disclosure of such information without the authorization of the person to whom such information pertains, or as otherwise permitted by law. A general authorization for the release of medical or other information may not be sufficient for the re-release of this information.

A COPY OF THIS DOCUMENT ACCOMPANIES THE RECORDS DISCLOSED
UC4120 120880 Rev 2/18/08 **White - Chart /Yellow - Copy Patient**

