ORLANDO HEALTH® | ARNOLD PALMER HOSPITAL For Children

Practice Management
83 W. Columbia St., Orlando, FL 32806
tel 321.841.3064 • fax 321.843.6854

LINE UP PATIENT I.D. LABEL HERE

AUTHORIZATION TO OBTAIN, RELEASE, OR REVIEW PROTECTED HEALTH INFORMATION

PATIENT AND REQUESTOR INFORMATION:

Patient Name:_____ Date of Birth_____ / _____ / _____

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

Requestor Name: _____ I.D. Shown_____ Method of Delivery: ❑ Mail ❑ Electronic

Email Address: _____ Telephone Number:_____ ❑ Pick-Up ❑ Paper ❑ CD

PLEASE SPECIFY IF YOU WANT US TO RELEASE INFORMATION TO, OBTAIN INFORMATION FROM, OR REVIEW INFORMATION

I hereby allow Arnold Palmer Pediatric Specialty Practices to:

❑ Release Information to:
Name: _____
Address: _____
Phone Number: _____
Fax Number: _____
(Orlando Health Policy - We only fax to medical facilities)

❑ Obtain Information From:
Facility Name: _____
Facility Address: _____
Facility Phone Number: _____
Facility Fax Number: _____

Fax Records to:
APH Health Info Management: 321.843.6854
Mail Records to: 83 W. Columbia St., Orlando, FL 32806

❑ Allow Review of Medical Records:
Name of Reviewer: _____
Relation to Patient: _____

Check Applicable Practices Where Patient Is Seen:

❑ Craniomaxillofacial ❑ Neurosurgery
❑ Endocrine ❑ Neuropsych
❑ Gastroenterology ❑ Orthopedics
❑ Genetics ❑ Pulmonology
❑ Infectious Diseases ❑ Physiatry
❑ Other:_____

Records to be Released

❑ Complete Record ❑ Radiology
❑ Office Notes ❑ Operative Report
❑ Test Results
❑ Other (specify) _____

Purpose of Release:

❑ Insurance ❑ Continued Treatment
❑ Legal Actions ❑ Personal Use
❑ Family and Medical Leave Act/Disability Forms
❑ Other *(please specify)*:_____
_____

This authorization will expire on the following date, event or condition: _____
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 below or otherwise required by law.

May NOT include information related to (please initial):
_____ HIV/AIDS ____ Mental Health ____ Drug and/or Alcohol Abuse ____ Genetic Counseling/Testing Information

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. I understand that I will receive a signed copy of this form.

_____ _____ _____
Patient/Legal Representative or Parent/Legal Guardian Signature Date Time

OFFICIAL USE ONLY:

Name_____Date:_____ Time_____ ❑ Releasing Information
Number of Pages Copied: _____ ❑ Assisting with Review

❑ **I wish to revoke this authorization.** Signature:_____Date:_____ Time_____