



ORLANDO HEALTH
1414 Kuhl Ave.
Orlando, FL 32806 MP97

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

OFFICIAL USE ONLY:
 Name _____ Date: _____ Releasing Information
 Number of Pages Copied: _____ ID Shown _____ Assisting with Review

INTERPRETER ONLY
 (Please Print)
 Name: _____ Agency: _____
 Telephone: _____ Language: _____



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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: _____