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:** | |
| **Street:** | **City:** | **State:** | **Zip:** |

| WHERE ARE YOU REQUESTING RECORDS FROM (HOSPITAL NAME, PRACTICE NAME, OR PROVIDER NAME)? | |
|---|---|
| **Name:** | **Phone:** |
| **Mailing Address:** | **Fax:** |
| **Multiple Locations** (additional locations you need records from, name only): | |

| WHO DO YOU WANT THE RECORDS SENT TO? | |
|---|---|
| **Name:** | **Phone:** |
| **E-Mail:** | **Fax:** |
| **Full Mailing Address:** | |

## WHAT RECORDS ARE YOU REQUESTING?

**Records for Time Period / Dates of Service:** _____ / _____ / _____ through _____ / _____ / _____ **Format: MM/DD/YYYY**

- ☐ Abstract (Notes & Diagnostic Results)
- ☐ Consultation Notes
- ☐ Discharge Summary
- ☐ Emergency Room Notes
- ☐ Entire Record
- ☐ History and Physical Notes
- ☐ Progress Notes
- ☐ Operative/Procedure Notes
- ☐ Therapy Notes
- ☐ Lab Results
- ☐ Pathology Results
- ☐ Radiology Report (CT, MRI, X-Ray, etc)
- ☐ Radiology Images (CD/DVD or Email)
- ☐ Other (please specify): _____

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

## HOW DO YOU WANT THE MEDICAL RECORDS TO BE DELIVERED?

| **Electronic Delivery:** | **Mail Delivery:** | **In Person Pick-Up:** |
|---|---|---|
| ☐ MyChart (Patient Portal) | ☐ Paper (fees may apply) | ☐ Paper (fees may apply) |
| ☐ Secure E-Mail (encrypted, size limits) | ☐ Electronic (CD/DVD) | ☐ Electronic (CD/DVD) |
| ☐ Fax (Medical Facilities only) | | |

## HOW DO YOU WANT THE RADIOLOGY IMAGES TO BE DELIVERED (IF APPLICABLE)?

| **Electronic Delivery:** | **Mail Delivery:** | **In Person Pick-Up:** |
|---|---|---|
| ☐ Email (Powershare) | ☐ CD / DVD Format | ☐ CD / DVD Format |

## REQUESTOR'S NAME AND SIGNATURE

| **Print Your Name (First, Last):** | **Signature:** |
|---|---|
| **Date/Time:** | **Expiration Date, Event, or Condition** (optional): |

**Relationship if Not Patient:** ☐ Parent ☐ Legal Guardian ☐ Foster Parent ☐ Healthcare Power of Attorney, Surrogate, Proxy

☐ Other (specify): _____

## SUBMIT COMPLETED FORM TO:

| | |
|---|---|
| **Mail**: 1414 Kuhl Ave., MP69, Orlando, FL 32806 | **Fax**: 321-843-6411 |
| **Walk In locations listed at** www.orlandohealth.com/medicalrecords | **E-Mail**: medicalrecords@orlandohealth.com |

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## EXPLANATION OF FORM

## PATIENT REQUEST FOR PROTECTED HEALTH INFORMATION (MEDICAL RECORDS)

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.: _____ | Team Member Name & I.D.: | Team Member/Reader Name & I.D.: |
| Agency/Interpreter Name and/or I.D.: _____ | _____ | _____ |
| ☐ Video remote ☐ Tel ☐ In-person Language: _____ | Language: _____ | Other: _____ |