Authorization for Use or Disclosure of Protected Health Information ("PHI") Maintained by UF Health*

Patient Name	Date of Birth	Medical Record Number, if known

Address	City	State	Zip

Telephone # ( )	Last 4 digits of SSN (Optional)	☐ Check if patient is an employee of UF Health

Name of Requestor (if other than patient)	Relationship to Patient ☐ Parent ☐ Legal Guardian ☐ Other:
Requestor's Address & Phone Number	Verification of Identity: ☐ Personally known ☐ Driver's License/State ID ☐ Other:

By signing this form, I authorize the following:

To the facility checked to send PHI	To share PHI with the person / facility below
☐ **UF Health Shands Hospital (includes Shands at AGH)** PO Box 100345, Gainesville, FL 32610-0345 ▪ Phone: (352) 594-0909 ▪ Fax: (352) 265-1098	Person or Facility ☐ Check here if same as patient above
☐ **UF Health Shands Rehab Hospital** ▪ 4101 NW 89th Boulevard, Gainesville, FL 32606 Phone: (352) 265-5491 ▪ Fax: (352) 265-5426	Address ☐ Check here for records pick-up only
☐ **UF Health Shands Psychiatric Hospital** ▪ 4101 NW 89th Boulevard, Gainesville, FL 32606 Phone: (352) 265-5497 ▪ Fax: (352) 265-5426	
☐ **UF Health Shands HomeCare** ▪ 3515 NW 98th Street, Gainesville, FL 32606 Phone: (352) 265-0789 ▪ Fax: (352) 265-9276	
☐ **UF Health Shands Hospital – Radiology** ▪ PO Box 100374, Gainesville, FL 32610-0374 Phone: (352) 265-0107 ▪ Fax: (352) 265-6978	Telephone # ( ) Attn:
☐ **University of Florida clinics and physicians' offices**	

What PHI may be shared? *(Check all that apply)*:				☐ Mental Health/Psychiatric Treatment
☐ History and Physical	☐ Operative Report(s)	☐ Discharge Summary	☐ Emergency Room Record	☐ Alcohol or Substance Abuse Treatment
☐ Problem List	☐ Medication List	☐ Treatment Notes	☐ Lab/Pathology Reports	☐ Sexually Transmitted Disease Treatment
☐ Genetic Testing	☐ Other:		☐ Radiology Reports/Films	☐ HIV or AIDS Treatment(s) or Test(s)

Is this needed for a doctor's appointment?	Write date below	**Are there specific dates needed?**	Write date below
What is the purpose of this request?	☐ Treatment/Continued Care ☐ Payment/Billing ☐ Personal Use ☐ Other:		

To request access to or copies of records in electronic PDF form, please provide a valid and clear e-mail address below. You will receive an e-mail from HealthPort, that e-mail will tell you how to get the records.

WARNING: If you request your records to be sent to e-mail, there may be some level of risk that the records could be read by a third party.

This authorization permits the UF Health* entities above to use and disclose (share) certain protected health information (PHI). By signing this authorization, I am giving permission for UF Health to release some of my PHI for a specific purpose or use as I have directed. The PHI may include information about mental health, substance and/or alcohol abuse, HIV/AIDS, and sexually transmissible diseases. This authorization may be used until it expires to share the same type of PHI indicated above which may be created in the future.

***Note:** If these records contain any information from previous providers or information about drug/alcohol abuse, genetic test results, HIV/AIDS status, mental health, sexually transmitted disease, or tuberculosis, you are hereby authorizing disclosure of this information.*

I understand that this authorization will remain in effect for one (1) year or until I revoke it in writing (i.e. tell UF Health to cancel it). I understand that I have the right to revoke this authorization, but only to the extent that UF Health has not already taken action based on this authorization. I may revoke this authorization by providing a written statement to the HIM Department at the facility checked above. If I refuse to sign this authorization, doing so will not affect my treatment, payment, enrollment, eligibility for benefits or the quality of care that I will receive.

I hereby release and discharge UF Health, all of its successors and all persons acting under its permission and authority from any liability that may arise from the release of PHI as I have directed. I understand that PHI shared per this authorization may no longer be protected by state law or the federal health privacy law and could be re-disclosed by the person or entity that receives it.

I am aware that I may be charged a fee for this request as follows: Paper Copies – up to $1.00 per page (plus applicable tax and handling); Electronic Copies – fee associated with labor, supplies (i.e. cost of a computer disk), and postage. Additional fees apply for summary requests or explanations. Fees are waived when the sharing of PHI is to a health care provider for continuing treatment.

**For purposes of this agreement, UF Health includes the University of Florida Board of Trustees for the benefit of the University of Florida College of Medicine, Shands Jacksonville Medical Center, Inc. and Shands Teaching Hospital and Clinics, Inc.*

Signature of patient / patient representative _____ **Date** _____

UFHealth PHYSICIANS

UFHealth SHANDS

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For UF Health Use Only	ABS	DC	FS	PN
Dates of service:	AN	EC	HP	PO
	AU	EE	IM	PR
# pages Date	CC	EK	LA	PS
Circle: Mail Fax Pickup E-delivery	CH	EM	LD	PT/OT
Other:	CL	EN	OP	PX
	CO	ER	PF	XX
Checked ID? ☐ **Yes** ☐ **No initial** _____			Tech	

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Distribution: Original – Patient Record; Copy – Requestor