PALM BEACH HEALTH NETWORK
Stronger Together. For You.
#PBHNProud

ACCOUNT NO(s): _____
_____
_____

3RF

☐ Delray Medical Center ☐ Florida Coast Medical Center ☐ Good Samaritan Medical Center ☐ St. Mary's Medical Center
☐ Palm Beach Gardens Medical Center ☐ West Boca Medical Center

Patient Name	**Last:**	**First:**	**Middle:**	
Home Address		**City:**	**State:**	**Zip:**
Home Telephone		**Social Security #:**		
Date of Birth		**Date of Hospital Visit(s) being requested:**		
Email:				

Specify Information to be Disclosed:

☐ Face Sheet	☐ Radiology Reports/Mammo	☐ Laboratory ☐ AM Labs Only	☐ EEG
☐ Discharge Summary	☐ Anesthesia Records	☐ ER	☐ Respiratory
☐ History & Physical	☐ Pathology	☐ Orders	☐ Medications
☐ Consultations	☐ EKG/Stress Test/Holter	☐ Progress Notes	☐ Biopsychosocial Assessment
☐ Operative Reports	☐ Echo	☐ Rehab (PT, OT, Speech)	☐ Other

Original Materials Released:
Blocks: _____
Slides: _____

RECIPIENT: Name of person(s) to whom PALM BEACH HEALTH NETWORK may disclose my health information.

☐ **Mail to:** _____
(Please Print Name and Address or Email Address, if Preferred)

☐ **Do Not Mail;** records will be picked up by: _____
(Please Print)

TERM: This Authorization will remain in effect:
☐ From the date of this Authorization until _____ (Date)
☐ Until PBHN fulfills this request
☐ Until the following event occurs _____
☐ Until withdrawn in writing

PURPOSE: I authorize PALM BEACH HEALTH NETWORK to use or disclose my health information (this includes the super confidential health information on the back of this form) during the term of this Authorization for the following specific purpose(s):
☐ Continuity of Care ☐ Personal Use
☐ Patient Transfer ☐ Other

I understand that once PALM BEACH HEALTH NETWORK discloses my health information to the recipient, PALM BEACH HEALTH NETWORK cannot guarantee that the recipient will not redisclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.

I understand that I may refuse to sign or may revoke (at any time) this Authorization for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of my treatment at PALM BEACH HEALTH NETWORK; except, however, if my treatment at PALM BEACH HEALTH NETWORK is for the sole purpose of creating health information for disclosure to the recipient identified in this Authorization, in which case PALM BEACH HEALTH NETWORK may refuse to treat me if I do not sign this Authorization.

DOB: «BirthDate»
«AdmitDate»
«Age» «Gender»
ACCT# «PatientNumber»
Room: «Room»-«Bed»
«PatientName»
«AttendingDoctorName» MR# «MedicalRecordNumber»

I understand that this Authorization will remain in effect until the term of this Authorization expires or I provide a written notice of revocation to PALM BEACH HEALTH NETWORK's Privacy Office at the address listed below. The revocation will be effective immediately upon PALM BEACH HEALTH NETWORK's receipt of my written notice, except that the revocation will not have any effect on any action taken by PALM BEACH HEALTH NETWORK in reliance on this Authorization before it received my written notice of revocation.

By applying a check next to a category of super confidential information listed below and signing on the appropriate line after the checked box, I specifically authorize the use and/or disclosure of the type of super confidential information indicated next to my signature, if any such information will be used or disclosed pursuant to this Authorization:

- ☐ Mental Illness _____
- ☐ Developmental Disability _____
- ☐ Psychotherapy Notes _____
- ☐ HIV / AIDS Testing or Treatments (regardless of result) _____
- ☐ Venereal Disease _____
- ☐ Abuse of an Adult with a Disability _____
- ☐ Sexual Assault _____
- ☐ Child Abuse or Neglect _____
- ☐ Genetic Testing _____
- ☐ Drug/Alcohol TX _____
- ☐ Other

I have read and understand the terms of this Authorization and I have had an opportunity to ask questions about the use and disclosure of my health information. By my signature below, I hereby, knowingly and voluntarily, authorize PALM BEACH HEALTH NETWORK to use or disclose my health information in the manner described above.

_____ _____

Signature of Patient **Date**

If patient is a minor or is otherwise unable to sign this Authorization, obtain the following signatures:

_____ _____ _____

Signature of Personal Representative **Description of Authority** **Date**

For Internal Use Only: The identity of the requestor has been validated either with a government issued picture ID, such as a driver's license or passport, or comparison of signatures documented in the medical records.

_____

Signature of Employee Validating Identity