Health First

Authorization to use and disclose health information

(Request copies of medical records)

Health Information Management

For Cape Canaveral Hospital, Holmes Regional Medical Center, Palm Bay Hospital, Viera Hospital, and their affiliates.

Patient name _____ Date(s) of service requesting _____

Date of birth _____ SSN# _____

1. I authorize the use or disclosure of the above named individual's health information as described below.
2. The type of information to be used or disclosed (check the appropriate items and include other information as needed) is:

   ___History and physical ___ER record ___Discharge summary ___Radiology reports

   ___Cardiology reports ___Physician orders ___Progress notes ___Entire medical record

   ___Lab results (specify dates) _____

   ___Consultation report(s) by _____

   ___Other (please specify, i.e., vascular lab, pulmonary or other ancillary visits) _____
3. I understand the health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.
4. I authorize Health First, Inc. to make the disclosure to the individual or organization identified below.
5. The items indicated above may be used by or disclosed to the following individual or organization:

   Name_____ Phone_____ Fax _____

   Address _____
6. This information for which I am authorizing disclosure will be used for the following purpose:

   ___My personal records ___Continued care/Dr._____ ___Legal purpose

   ___Other, please describe _____
7. I understand I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Health Information Management Department where my information is maintained. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.
8. This authorization will expire six months from the date signed, which will be (date) _____. (If the expiration date of this authorization is not completed, this authorization will expire six months from the date of which it was signed.)
9. I understand that once the above information is disclosed, it may be redisclosed by the recipient and the information may not be protected by federal privacy laws or regulations.
10. I understand authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment.
11. If I have questions about disclosure of my health information, I can contact the Health Information Management (Medical Records) Department where I received treatment.

_____

Signature of patient or legal representative Date

_____

Relationship to patient (if signed by legal representative) Documentation establishing relationship (specify document)

_____

Signature of witness Date

Instructions for authorizing use and disclosure of health information

(Requesting copies of medical records)

To request copies of your medical records, complete this form and send it to the Health Information Management Department at the facility where you received treatment. The form can be submitted by fax, mail, or in person to the address(es) or fax number(s) listed below. Please allow 4 working days for the request to be processed.

If you are requesting copies for someone other than yourself, you will need to provide legal documentation verifying guardianship, power of attorney, executorship, or next-of-kin relationship (in the case of a decedent). Parents may request copies of their minor child's records if they have legal custody of the child and the child is not legally emancipated. This form must be signed by the patient or the legal representative. Verification of identity is required.

To request copies for your primary care physician or other health care provider, designate the physician or provider as the recipient of the copies on Line 5 of the form. The copies will be sent directly to their address.

Cape Canaveral Hospital
Attention: Health Information Management
701 West Cocoa Beach Causeway
Cocoa Beach, FL 32931

Fax: 321-799-7138
Hours: Monday through Friday, 8:30am to 4pm
Office Location: On the second floor of the hospital, on the hall between the Administration offices and the nursing unit

Holmes Regional Medical Center
Attention: Health Information Management
1350 South Hickory Street
Melbourne, FL 32901

Fax: 321-434-8935
Hours: Monday through Friday, 8:30am to 4pm
Office Location: On the first floor of the hospital, in the main hall between the cafeteria and Administration

Palm Bay Hospital
Attention: Health Information Management
1425 Malabar Road NE
Palm Bay, FL 32907

Fax: 321-434-8104
Hours: Monday through Friday, 8:30am to 4pm
Office Location: On the first floor of the hospital, on the left side of the lobby at the west entrance

Viera Hospital
Attention: Health Information Management
8745 North Wickham Road
Melbourne, FL 32940

Fax: 321-434-9467
Hours: Monday through Friday, 8:30am to 4pm
Office Location: On the first floor of the hospital, on the left side of the lobby at the main (north) entrance