

Instructions: Please complete form in its entirety. Items not checked or unfilled blanks are assumed to be non-applicable or specifically not authorized for release. The release is not valid unless signed and dated by patient or legally authorized representative.

I AUTHORIZE _____ (Facility) **TO DISCLOSE/RELEASE THE INFORMATION BELOW TO**

NAME OF NON-SMH FACILITY

SARASOTA MEMORIAL HEALTH CARE SYSTEM – Facility Phone: _____ **Facility Fax:** _____

I AUTHORIZE SARASOTA MEMORIAL HEALTH CARE SYSTEM TO DISCLOSE/RELEASE THE INFORMATION SPECIFIED BELOW FROM THE HEALTH RECORDS OF:

- Sarasota Memorial Hospital / Emergency Care / Urgent Care Location: _____
- First Physicians Group (FPG) Location/Physician: _____
- Sarasota Memorial Nursing and Rehabilitation Center

Patient's Name: _____		MI
Last	First	
Previous Name If Applicable: _____	Birth Date _____	Telephone # _____

THIS INFORMATION IS TO BE DISCLOSED/RELEASED TO: (Include Address)

Recipient Name: _____

Recipient Address: _____

Recipient Phone # _____ Recipient Fax: _____

COVERING THE FOLLOWING TIMEFRAME(S) OF HEALTHCARE SERVICES: From – Date ____/____/____ To – Date ____/____/____

FOR THE PURPOSE OF: Continuing Treatment At the Request of the Patient Third Party Recipient Specify: _____

THE FOLLOWING INFORMATION MAY BE DISCLOSED/RELEASED:

- All Clinical Pertinent Documents
- Radiology Images on CD or Electronic Link to Image
- Cardiology Images on CD or Electronic Link to Image
- Billing Records
- Other (Please Specify) _____

VIA THE FOLLOWING FORMAT:

Encrypted email to: _____ Fax Mail to Specified Address

I understand that this will include information relating to (initial if applicable):	
_____	Behavioral Health
_____	Substance Use Disorder (SUD) Treatment
_____	Sexually Transmitted Disease / Acquired immunodeficiency syndrome (AIDS) /Human Immunodeficiency Virus (HIV)
_____	Genetic Testing
_____	Reproductive Health (minors)

POSSIBILITY OF REDISCLOSURE: I understand that any information released may be subject to re-disclosure by the recipient and may no longer be protected by state and federal regulations. If the recipient is a health care provider, health plan, or other entity covered by HIPAA, the information may be further used or disclosed in accordance with HIPAA and 42 CFR Part 2, as applicable. However, SUD treatment records disclosed pursuant to this authorization are protected under 42 CFR Part 2. They may not be used to initiate or substantiate any criminal charges against me, or to conduct any criminal investigation of me, and may not be used in any civil, criminal, administrative, or legislative proceedings against me, without my separate written consent or a court order issued under 42 CFR Part 2. Any further disclosure of SUD treatment records by the recipient is prohibited unless expressly permitted by 42 CFR Part 2 or with my written consent.

EXPIRATION AND REVOCATION: I understand that this authorization is valid for 6 months from the date I sign it, or until _____ (date or event), not to exceed 24 months. I have the right to revoke this authorization in writing at any time by contacting SARASOTA MEMORIAL HOSPITAL, ATTENTION: HEALTH INFORMATION MANAGEMENT SERVICES, 1700 S. Tamiami Trail, Sarasota, FL 34239-9989. The revocation will take effect on the day it is received except to the extent it has already been acted upon or if the authorization was obtained as a condition of obtaining insurance coverage.

Note: This authorization will be processed at the time of receipt and only relates to releasing what is on this specific request. I further understand that this authorization permits Sarasota Memorial Health Care System (or the Facility) to communicate with the Recipient the information described in this authorization, and that staff may rely on this authorization to provide testimony or statements limited to such information in depositions, hearings, or other legal proceedings. I also authorize such parties to engage in communications as reasonably necessary to process and fulfill this request.

CONDITIONS OF TREATMENT: I understand that Sarasota Memorial Health Care System (or the Facility) cannot condition treatment, payment, enrollment in a health plan, or eligibility for benefits for health care upon my signing this authorization.

Signature of Patient or Legally Authorized Representative* _____
Date

*If other than patient signing, state relationship: _____

Signature of Witness _____
Date

A COPY OF THIS SIGNED AUTHORIZATION WILL BE PROVIDED TO THE PATIENT OR LEGALLY AUTHORIZED REPRESENTATIVE UPON REQUEST.

SARASOTA MEMORIAL HEALTH CARE SYSTEM
AUTHORIZATION TO RELEASE PATIENT INFORMATION

