Cooper Family Medical

Request for Protected Health Information / Patient Authorization for Release of Records

Patient Name: ______________________________ S.S.# ______________

Date of Birth ______________ Patient Phone Number(s): ______________

Treatment Dates to Be Released: ______________________________

Type of Visit: Inpatient ☐ Outpatient Surgery ☐ ER ☐ Outpatient Test ☐ Therapy ☐ Other ☐

PERSON(S) / ORGANIZATION(S) AUTHORIZED TO MAKE DISCLOSURE:

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RELEASE INFORMATION TO: (*recipient of disclosure*)

Name: Cooper Family Medical
Address: 5123 Fourth Avenue Circle East
Apt, Suite or PO #: ______________
City, State, and Zip: Bradenton, Florida 34208
Phone: 941-744-5510
Fax: 941-744-5166

PURPOSE OF THE DISCLOSURE: ☐ Insurance ☐ Legal ☐ Continuing Care ☐ Personal ☐ Other (specify) ______________

SPECIFIC DESCRIPTION OF THE INFORMATION TO BE DISCLOSED:

- ☐ Face Sheet
- ☐ Consent Form
- ☐ Discharge Summary
- ☐ History & Physical
- ☐ Operative Reports
- ☐ Pathology Reports
- ☐ ER Record
- ☐ Therapy Records
- ☐ Radiology Report
- ☐ Mammogram
- ☐ EKG
- ☐ Consultations
- ☐ Physician Progress Notes
- ☐ Physician's Orders
- ☐ Lab Results
- ☐ Abstract of all records
- ☐ Copy of Itemized Bill
- ☐ Radiology disc/films
- ☐ Other (specify)__________

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SPECIFIC INFORMATION TO <u>NOT</u> BE DISCLOSED: ______________________________

I understand that the purpose of this authorization is for the use and/or disclosure of my protected health information (PHI) and that it may contain information that is protected under state laws and federal regulations. I understand that once the above information is disclosed it may be subject to re-disclosure and will no longer be protected by Privacy Protection Rules. I understand that I have the right to revoke this authorization at any time and that my revocation must be submitted to the HIM Department.. I understand that my revocation is not effective to the extent that the persons or organizations in which I have authorized to use and/or disclose my protected health information have acted in reliance upon this authorization. I understand that I may refuse to sign this authorization and my refusal to sign will not affect my ability to receive treatment, payment enrollment, or eligibility for benefits. I understand that I will be given a copy of this authorization upon my signature.

I hereby authorize this medical facility and/or ScanSTAT Technologies to disclose/release medical records and other information obtained in the course of my diagnosis and/or treatment. I agree to pay copy charges if applicable.

I hereby release this medical facility and/or ScanSTAT Technologies from any liability which may result from this disclosure of confidential medical information or which may arise of the result of the use of the information contained in the information released. Unless withdrawn, this consent will expire 90 days from the date signed.

This information may include Medical/Surgical, Psychiatric, Substance Abuse and HIV/AIDS information. I authorize that this information may be faxed when applicable.

______________________________ ______________
PATIENT'S SIGNATURE **DATE**

______________________________ ______________
PATIENT'S REPRESENTATIVE SIGNATURE AND AUTHORITY TO SIGN **DATE**

______________________________ ______________
WITNESS **DATE**