

- Pick-up e-Delivery
 Mail Out CD MyChart

**Authorization for Release of
Confidential Medical Records**

Medical Record #:
Account #:

1. Person(s) or class of persons authorized to use / disclose the information:
- | | |
|---|--|
| <input type="checkbox"/> Memorial Regional Hospital /
Joe DiMaggio Children's Hospital | <input type="checkbox"/> Memorial Regional Hospital South
<input type="checkbox"/> Memorial Hospital West Cancer Center |
| <input type="checkbox"/> Memorial Hospital West | <input type="checkbox"/> Memorial Physician Practice(s) (specify) _____ |
| <input type="checkbox"/> Memorial Hospital Miramar | <input type="checkbox"/> Memorial Regional Hospital Cancer Center |
| <input type="checkbox"/> Memorial Hospital Pembroke | <input type="checkbox"/> All Memorial Healthcare System facilities |
| <input type="checkbox"/> Memorial Home Health | <input type="checkbox"/> Memorial Primary Clinic |
| <input type="checkbox"/> Memorial Manor Nursing Home | <input type="checkbox"/> Other (specify) _____ |

2. By signing this, I authorize the above to disclose protected health information about the person named below.
Patient Name (Print): _____ Date of Birth: _____

3. Please disclose the exact information to be disclosed, including dates of service:
- | | | |
|---|---------------------------|--|
| <input type="checkbox"/> Abstract (Includes * reports shown below)
OR the specific records marked below: | <u>Date(s) of Service</u> | <u>Date(s) of Service</u> |
| <input type="checkbox"/> *Face Sheet | _____ | <input type="checkbox"/> *Pathology Reports _____ |
| <input type="checkbox"/> *Discharge Summary | _____ | <input type="checkbox"/> *Consultation Reports _____ |
| <input type="checkbox"/> *Emergency Room | _____ | <input type="checkbox"/> *EKG Reports _____ |
| <input type="checkbox"/> *Outpatient Records | _____ | <input type="checkbox"/> *Clinical Lab Reports _____ |
| <input type="checkbox"/> *History & Physical | _____ | <input type="checkbox"/> *X-ray Reports _____ |
| <input type="checkbox"/> *Progress Notes | _____ | <input type="checkbox"/> All medical records _____ |
| <input type="checkbox"/> *Operative Records | _____ | <input type="checkbox"/> *Other (specify) _____ |
| <input type="checkbox"/> *Newborn ID Sheet | _____ | |
- Note: X-ray films must be obtained from the Radiology Department.

4. This information is to be released to:
Name _____
Address _____
I request my records be sent to me at this e-mail address: _____

5. I acknowledge the following statements:
- I understand that I may revoke this Authorization at any time by sending a written request to the privacy officers at any of the facilities. (See back of form.) Such revocation will not have any effect on any action taken by Memorial Healthcare System before the revocation.
 - This authorization will expire six (6) months from the date of signature, or when revoked or on the following date _____.
 - I understand that this information may include information relating to: 1) Acquired Immune Deficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV) Infection, 2) Mental or behavioral health or psychiatric care. 3) Treatment of drug or alcohol abuse.
 - I understand that the information disclosed pursuant to this Authorization may be subject to re-disclosure by the party who receives it because it may no longer be protected by the federal privacy laws.
 - I understand that records in electronic form can be distributed on a wide scale with relative ease and losses or unintended releases of the requested information may occur under circumstances beyond the control of MHS, its release of information vendor or the person making the request. By requesting records in this format the Requestor is knowingly and voluntarily assuming this risk and all consequences, losses and damages that might result.
 - If Memorial Healthcare System has requested this Authorization, I understand that Memorial Healthcare System will give me a copy of this Authorization form after I sign it.
 - I understand that Memorial Healthcare System may not condition treatment, payment, enrollment or eligibility of benefits on the completion of this Authorization.
 - This information will be used / disclosed for the following purpose(s): _____

This section also applies when Memorial Healthcare System requests the Authorization for *Marketing* purposes *only*. Will MHS receive compensation for this disclosure? No _____ Yes _____ If yes, compensation will be paid by _____ for disclosing information to _____

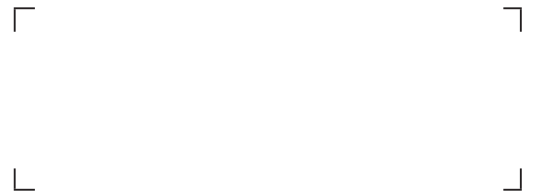
Signature of patient: _____ Phone # _____ Date: _____
-OR-
Signature of patient's legal personal representative: _____ Date: _____
Printed name of patient's representative: _____ Phone: _____
Relationship to patient / authority to act for patient: _____



AUTHORIZATION FOR
RELEASE OF CONFIDENTIAL
MEDICAL RECORDS
ENGLISH



PATIENT/LABEL



Authorization for Release of Confidential Medical Records

Contact Information

<p align="center">Attn: Release of Information/HIM Memorial Regional Hospital 3501 Johnson Street Hollywood, Florida 33021</p>	<p align="center">Attn: Release of Information/HIM Joe DiMaggio Children's Hospital 3501 Johnson Street Hollywood, Florida 33021</p>
<p align="center">Attn: Release of Information/HIM Memorial Regional Hospital South 3600 Washington Street Hollywood, Florida 33021</p>	<p align="center">Attn: Release of Information/HIM Memorial Hospital West 703 North Flamingo Road Pembroke Pines, Florida 33028</p>
<p align="center">Attn: Release of Information/HIM Memorial Hospital Miramar 1901 S.W. 172nd Avenue Miramar, Florida 33029</p>	<p align="center">Attn: Release of Information/HIM Memorial Hospital Pembroke 7800 Sheridan Street Pembroke Pines, Florida 33024</p>
<p align="center">Attn: Release of Information/HIM Memorial Regional Cancer Center 3501 Johnson Street Hollywood, Florida 33021</p>	<p align="center">Attn: Release of Information/HIM Memorial Manor 777 S. Douglas Road Pembroke Pines, Florida 33025</p>
<p align="center">Attn: Release of Information/HIM Memorial Primary Care Clinic 3501 Johnson Street Hollywood, Florida 33021</p>	<p align="center">Attn: Release of Information/HIM Memorial West Cancer Center 703 North Flamingo Road Pembroke Pines, Florida 33028</p>
<p align="center">Attn: Release of Information/HIM Memorial Physician Practice(s) 3501 Johnson Street Hollywood, Florida 33021</p>	<p align="center">Attn: Release of Information/HIM Memorial Home Health 3501 Johnson Street Hollywood, Florida 33021</p>



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PATIENT/LABEL
