

**AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION**

*\*Fee may apply for production of records\**

Medical Records Department Phone: 904-345-7235 | Fax: 904-345-7213 | Email: Brooks.ROI@brooksrehab.org

**Section A: (All sections must be complete to be valid)**

<b>Patient Name:</b>	<b>Date of Birth:</b>	<b>Social Security No.:</b>
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I hereby authorize Brooks Health System to release/receive my confidential health information to/from:

<b>Recipient's Name/Records Released To:</b>	<b>Recipient's Phone:</b>	<b>Recipient's Fax:</b>
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<b>Address:</b>	<b>City:</b>	<b>State:</b>	<b>Zip:</b>
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**Email Address (Use ALL CAPS) :**

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<b>Purpose of Disclosure:</b>	<b>Type of Access:</b>	<b>Delivery Method: (If left blank, a paper copy will be provided)</b>
<input type="checkbox"/> Continuation of Care <input type="checkbox"/> Insurance Purposes <input type="checkbox"/> Legal Reason <input type="checkbox"/> Personal Use <input type="checkbox"/> Other (Specify) _____	<input type="checkbox"/> Copies of Record <input type="checkbox"/> Review of Record <input type="checkbox"/> Discussion of Record	<input type="checkbox"/> Fax (Physician Only) <input type="checkbox"/> Mailed – Paper Copy <input type="checkbox"/> Pick Up – Paper Copy <input type="checkbox"/> Email (Patient Only/Abstract Only) <input type="checkbox"/> Encrypted <input type="checkbox"/> Unencrypted <input type="checkbox"/> Dropbox (Patient Only) <input type="checkbox"/> Encrypted <input type="checkbox"/> Unencrypted

**Section B: Description of Information to be used or disclosed (All sections must be complete to be valid)**

Description:	Date(s) of Service Needed:	Location:
<input type="checkbox"/> Patient Abstract <input type="checkbox"/> History & Physical <input type="checkbox"/> Discharge Summary <input type="checkbox"/> Physician Reports <input type="checkbox"/> Physician Orders <input type="checkbox"/> Therapy Notes	<input type="checkbox"/> Nursing Notes <input type="checkbox"/> Radiology/Labs <input type="checkbox"/> Evaluations/Assessments <input type="checkbox"/> Medications <input type="checkbox"/> Billing Records <input type="checkbox"/> Other: _____	<input type="checkbox"/> All <input type="checkbox"/> Date Range: _____ <input type="checkbox"/> Brooks Rehab Hospital <input type="checkbox"/> Brooks Home Health <input type="checkbox"/> Outpatient Rehab Clinic <input type="checkbox"/> Behavioral Health <input type="checkbox"/> Bartram Crossing SNF <input type="checkbox"/> Bartram ALF <input type="checkbox"/> University Crossing SNF <input type="checkbox"/> Brooks Medical Group

I acknowledge, and hereby consent to such, that the released information may contain HIV infection, AIDS or AIDS-related conditions, alcohol abuse, drug abuse, psychological or psychiatric conditions.  (Initials)

**I understand that:**

- My treatment, payment, enrollment or eligibility for benefits will not be conditioned on signing this authorization.
- I may revoke this authorization at any time in writing. I understand the revocation will not apply to information already released in response to this authorization.
- Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected by state or federal privacy regulations.
- Upon request, I may view and obtain a copy of the information to be used or disclosed pursuant to this authorization.
- Upon request, I may receive a copy of this form after I sign it.
- If I fail to specify expiration date or condition as set forth below, this authorization is valid for 6 months from the signature date.
- Patient information provided on a USB flash drive is for patient requests only and requires decryption with a provided password.
- I understand there are risks for obtaining my records through unencrypted email and accept responsibility for those risks. Risks include, but are not limited to, interception of email by a third party, read or accessed by unintended recipient, or sent to the wrong recipient.

**Section C: Signatures**

I have read the above and authorize the disclosure of the protected health information as stated.

<b>Signature of Patient/Guardian/Patient Representative:</b>	<b>Date:</b>	<b>Signature of Witness:</b>
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<b>Print Name of Patient/Guardian/Patient Legal Representative:</b>	<b>Relationship to Patient:</b>
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Authorization expires 6 months from the date signed unless otherwise specified below:

**Expiration Date/Event:**

**BROOKS INTERNAL USE ONLY**

Rev Jan 2022

<b>Date Request Received by Brooks Staff:</b>	<b>MRN#:</b>	<b>ACCT#:</b>
<b>Released to Active Patient (Outpatient ONLY) Employee Initials:</b>	<b>Patient ID Verified Employee Initials:</b>	<b>Comments:</b>