How to Complete the Brooks HIPAA Authorization for Release of Information

BROOKS Rehabilitation

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)

Patient Name:	Date of Birth:	Social Security No.:

I hereby authorize Brooks Health System to release/receive my confidential health information to/from:

Recipient/Records Released To:	Recipient's Phone:	Recipient's Fax:

Address:	City:	State:	Zip:

Email Address (Use ALL CAPS) :

Purpose of Disclosure:	Type of Access:	Delivery Method: (If left blank, a paper copy will be provided)
☐ Continuation of Care ☐ Insurance Purposes ☐ Legal Reason ☐ Personal Use ☐ Other (Specify)	☐ Copies of Record ☐ Review of Record ☐ Discussion of Record	☐ Fax (**Physician Only**) ☐ Mailed – Paper Copy ☐ Pick Up – Paper Copy ☐ Email (Patient Only/Abstract Only) ☐ Encrypted ☐ Unencrypted ☐ Dropbox (Patient Only) ☐ Encrypted ☐ 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:	
☐ Patient Abstract ☐ History & Physical ☐ Discharge Summary ☐ Physician Reports ☐ Physician Orders ☐ Therapy Notes	☐ Nursing Notes ☐ Radiology/Labs ☐ Evaluations/Assessments ☐ Medications ☐ Billing Records ☐ Other:	☐ All ☐ Date Range: _____ _____	☐ Brooks Rehab Hospital ☐ Outpatient Rehab Clinic ☐ Bartram Crossing SNF ☐ University Crossing SNF	☐ Brooks Home Health ☐ Behavioral Health ☐ Bartram ALF ☐ 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:

1. My treatment, payment, enrollment or eligibility for benefits will not be conditioned on signing this authorization.
2. 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.
3. 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.
4. Upon request, I may view and obtain a copy of the information to be used or disclosed pursuant to this authorization.
5. Upon request, I may receive a copy of this form after I sign it.
6. If I fail to specify expiration date or condition as set forth below, this authorization is valid for 6 months from the signature date.
7. Patient information provided on a USB flash drive is for patient requests only and requires decryption with a provided password.
8. 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.

Signature of Patient/Guardian/Patient Representative:	Date:	Signature of Witness:

Print Name of Patient/Guardian/Patient Legal Representative:	Relationship to Patient:

Authorization expires 6 months from the date signed unless otherwise specified below:

Expiration Date/Event:

BROOKS INTERNAL USE ONLY Rev Jan 2022

****Please do not fill out anything in the Brooks Internal Use Only section****

Contact Info for Medical Records Department

Who is the patient? Full name and date of birth required

Who is the recipient? Who is receiving the records? Please put all of their information in these fields.

Email: Please note full records cannot be emailed; we have a limit of 25 pages for emailed records. If selecting email as your delivery method you **must write the email address**

Purpose of Disclosure: What is the reason for the request?
Type of Access: What access is being authorized? Copies of records, a review of records only, or a discussion of records.
Delivery Method: How would you like the records to be received? Please note: some options may not be applicable to your request.

Description: What documents are being requested?
Dates of Service: Patient should specify the dates of service for the records they would like to be released. If all records are being requested, they should indicate ALL.
Location: Which Brooks location are records being requested from? Please check all that apply.

Patient or legal representative's **initials are required to release sensitive information** or **any records from our Behavioral Health Location**.

Signature of patient or legal representative required. If signing on behalf of a patient that is 18 or older you must provide the legal document proving you have the authority to do so.
Expiration Date: this authorization is valid for 6 months unless a date or time span is otherwise specified.

***What is a legal representative?** A court-appointed guardian or representative with legal documentation obtained through the court stating you have the authority to request medical records on the behalf of the patient. A copy of this document must be submitted with the request for medical records. For children under age 18, only a parent or court appointed guardian may authorize release of medical information.

***Patient abstract is provided free of charge**. This is a condensed version of your medical record. Additional fees may apply for a copy of your entire chart/visit.