Winter Haven Hospital
CASSIDY CANCER CENTER
Compassion. Innovation. Trust.

Patient Name: _____ DOB: ____/____/____

SS#: _____ Phone: _____ Medical Record #: _____

1. I authorize the use or disclosure of the above named individual's health information as described below.
2. The following individual or organization is authorized to make the disclosure:

☐ Other: _____
(Name) *(Address)*

_____
(City) *(State)* *(Zip)*

3. The type and amount of information to be used or disclosed is as follows: Date of Service _____ to _____

- ☐ Face Sheet
- ☐ ED Record
- ☐ Discharge Summary
- ☐ History & Physical
- ☐ Consultation
- ☐ Operative Report
- ☐ Psychiatric and/or Substance Abuse
- ☐ Laboratory
- ☐ Diagnostic Imaging
- ☐ Cardiology Reports
- ☐ HIV/AIDS
- ☐ Entire medical record
- ☐ Exchange, written and/or oral communication (BHD only)
- ☐ Other: _____

4. I understand that the information in my medical record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.
5. This information may be disclosed to and used by the following individual or organization:

Cassidy Cancer Center **863.292.4670**
(Name) *(Phone)*

Winter Haven Hospital, Inc.
(Address)

200 Avenue F, NE
(Address)

Winter Haven **FL** **33881** **863.292.4671**
(City) *(State)* *(Zip)* *(Fax)*

6. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Health Information Management Services department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire 6 months.
7. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed as provided CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact a manager of the Health Information Management department at (863) 297-1882.

For hospitals, the copy charge per Florida Statute 395.3025 is $1.00 per page plus actual postage. For medical practices, the copy charge per Florida Administrative Code 64B8-10.003 is $1.00 for the first 25 pages and $.25 for each page thereafter.

Signature of Patient or Legal Representative: _____ Date: _____

If Signed by Legal Representative, Relationship to Patient: _____

Signature of Witness: _____

WHH - 80145 Rev: 9/08 Exp: 9/10

AUTHORIZATION FOR RELEASE OF PATIENT HEALTH INFORMATION

Winter Haven Hospital, Inc.
Winter Haven, FL 33881

1R0I+