Record Request: Authorization to Use and Disclose Protected Health Information ("PHI") Maintained by UF Health*

**For purposes of this agreement, UF Health describes a collaboration of the University of Florida Board of Trustees for the benefit of the University of Florida College of Medicine, Shands Jacksonville Medical Center, Inc., Shands Teaching Hospital and Clinics, Inc., and Shands Recovery, LLC. Collectively, these entities are referred to as UF Health in this form.*

Patient Name	**Date of Birth**	**Medical Record #**	**Verification of Identity** ○ Driver's License/State ID ○ Personally known ○ Other
Patient's Address	**City**	**State** **Zip**	
Phone #	**Last 4 digits of SSN (Optional)**	○ Check if patient is an employee of UF Health	

Complete the section below only if the person requesting records is not the patient:

Name of Representative	**Relationship to Patient**	**Legal Authority**
Representative's Address & Phone Number	**Verification of Identity**	**Verification of Authority**

By signing this form, I authorize the release of PHI (i.e., medical records) as follows:

FROM the doctor, office, facility or other health care provider checked or written below:	**TO** the facility/ person below:
	☐ Check here if same as patient ☐ Check here for records **pick-up** only
Clinic or Department Name	Clinic, Person, or Organization
Address	Address
Phone: Attn:	Phone: Attn:

The following PHI may be released *(describe in detail or use the check boxes below):*

- ☐ History & Physical
- ☐ Operative Reports
- ☐ Discharge Summary
- ☐ Problem List
- ☐ Medication List
- ☐ Treatment Notes
- ☐ Emergency Room Record
- ☐ Radiology Reports / Images
- ☐ Lab/Pathology Reports
- ☐ Other ______________________________

I further authorize the release of the following information which may be included in the PHI:

- ☐ Behavioral Health treatment
- ☐ Alcohol or Substance Use Disorder
- ☐ STD/HIV/AIDS treatment or test(s)
- ☐ Genetic Testing

Is this needed for a doctor's appointment?	Write date below	**Are there specific dates needed?**	Write dates below

Purpose of this request: ○ Treatment/Continued Care ○ Payment/Billing ○ Legal ○ Personal Use ○ Other

Format of records? ○ Paper ○ DVD / CD ○ Thumb/Flash Drive ○ My UFHealth Patient Portal

○ Provided in electronic format to my e-mail account at: ______________________________

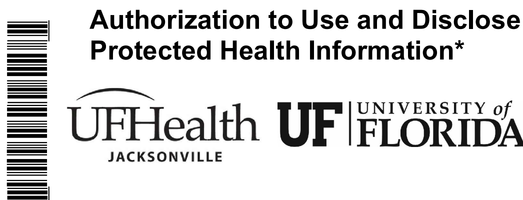
* You will receive an e-mail from our vendor (i.e. ScanSTAT) and that email will instruct you how to retrieve your records.

This authorization allows UF Health to use and disclose (release) certain PHI, which includes medical records, as I have directed.
I understand that:

- The PHI may include information about mental health, substance and/or alcohol abuse, HIV/AIDS, and STDs.
- I understand that substance use disorder records are protected under the Federal regulations governing Confidentiality and Substance Use Disorder Records, 42 C.F.R. Part 2, and HIPAA, 45 C.F.R. parts 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for by these regulations.
- This authorization may be used to share the same type of PHI indicated above which may be created in the future, until the expiration date.
- This authorization will remain in effect for **one (1) year** or until I revoke it in writing (i.e., tell UF Health to cancel it).
- I have the right to revoke this authorization at any time, but only to the extent that UF Health and the Part 2 program (if applicable) has not already relied on this authorization.
- I understand that I must revoke this authorization by writing to the Health Information Management Department at the organization named above and that the revocation will not apply to action already taken as a result of this authorization.
- I may refuse to sign this authorization and doing so will not affect my treatment, payment, enrollment, or eligibility for benefits or the quality of care that I will receive.
- I understand that PHI released per this authorization may no longer be protected by state law or the federal health privacy law and could be re-disclosed by the person or entity that receives it.

Signature of Patient / Patient Representative ______________________________ **Date** ______________

Authorization to Use and Disclose Protected Health Information*



Approved: 01/2015
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