

Name \_\_\_\_\_ Florida Tech ID \_\_\_\_\_

Date of Birth \_\_\_\_\_ Phone Number \_\_\_\_\_

I give authorization for the use or disclosure of the above individual's health information as described below:

**1) Released from:**       Premier Urgent Care/Holzer Health Center       Other \_\_\_\_\_

Facility Name \_\_\_\_\_

Address \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Phone # \_\_\_\_\_ Fax # \_\_\_\_\_

**Released to:**       Premier Urgent Care/Holzer Health Center       Other \_\_\_\_\_

 Fax       Pick up       Mail       Email

Facility Name \_\_\_\_\_

Address \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Phone # \_\_\_\_\_ Fax # \_\_\_\_\_

Email \_\_\_\_\_

Please Note: Email sent over the Internet or via fax are not necessarily secure. Florida Tech Holzer Health Center cannot guarantee the confidentiality or security of any information sent over the Internet when using email or by fax. The Florida Tech Holzer Health Center shall not be liable for any breach of confidentiality resulting from such an email.

**2) Type of information to be used or disclosed**

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> All Medical Records (excluding vaccine records)             | <input type="checkbox"/> Radiology Reports | <input type="checkbox"/> Progress Notes |
| <input type="checkbox"/> Vaccine Records (Administered at Holzer Health Center Only) | <input type="checkbox"/> Workers' Comp     | <input type="checkbox"/> Lab Results    |

**3) Including any of the following related super confidential information**

- |                                   |  |  |
|-----------------------------------|--|--|
| <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Mental Health with MD psychiatrist, Dr. Stump | <input type="checkbox"/> Reportable STDs |
|-----------------------------------|--|--|

**4) Dates of service requested**

- |   |   |
|---|---|
| <input type="checkbox"/> First year attended Florida Tech _____   | <input type="checkbox"/> Past 12 months |
| <input type="checkbox"/> Specific time period from _____ to _____ |   |

**5) The information I am authorizing disclosure for will be used for the following purpose**

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Continued Care                | <input type="checkbox"/> My Personal Records | <input type="checkbox"/> Legal Purposes |
| <input type="checkbox"/> Other (please describe) _____ |  |   |

I understand that this authorization will remain in effect for six (6) months and that I have the right to revoke this authorization at any time in writing presented to the health information management facility where my information is maintained. I further understand that the revocation will not apply to information that has already been disclosed in response to this authorization. I understand that once the information described above is disclosed, it may be re-disclosed by the recipient voluntary and I need not sign this form to ensure healthcare treatment. If I have any questions about the disclosure of my health information, I can contact the Medical Records Department where I have received treatment.

Signature of Patient or Legal Guardian\* \_\_\_\_\_ Date \_\_\_\_\_

\*If legal representative, relationship to patient \_\_\_\_\_

-----OFFICE USE ONLY -----

 Request Complete      Date \_\_\_\_\_      Initials \_\_\_\_\_      Comments \_\_\_\_\_