AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION (PHI)

FLORIDA HEALTH CARE PLANS ● P.O. BOX 9910 ● DAYTONA BEACH, FL 32120
PLEASE FAX MEDICAL RECORDS TO: 386-481-5009 OR 888-427-4544

FHCP Medical Record #: _____ Birth Date: _____

Patient Name and Maiden Name: _____ Last 4 SSN # _____

Address: _____

Home Phone #: _____ Work #: _____ ☐ MAIL ☐ PICKUP

I hereby authorize to release my: ☐ Paper Record ☐ Verbal Information ☐ Electronic Information

From Provider/Facility: _____

To: _____ Relationship: _____ Phone Number _____

☐ Myself	☐ Family Member Name:
☐ Family Member Name:	☐ Facility / Hospital / Doctor:
☐ Family Member Name:	☐ Other:

STREET ADDRESS CITY STATE ZIP CODE

Purpose for Release ☐ Continuing Care ☐ Legal ☐ Insurance ☐ Patient Request ☐ Other _____

Please release the following information contained in my medical record regarding my care and treatment.

☐ Office Visits	☐ Operative Reports	☐ Labs/Date drawn _____
☐ Immunizations	☐ Radiology Reports	☐ Other _____

Date(s) of Service: _____ **Pertinent information may be faxed for emergent need only.**

If this Sensitive Information is checked, the patient must initial.

☐ HIV/AIDS information _____	☐ Drug and Alcohol _____	☐ Psychiatric _____	☐ Other _____

I understand that this authorization extends to all or any part of my records, which may include psychiatric, alcohol/drug, and/or AIDS (Acquired Immunodeficiency Syndrome) information, any may include the result of an HIV test or the fact an HIV test was performed. I expressly consent to the release of information as designated above. I understand this authorization extends to release information via U.S. mail, telephone, or facsimile machine (fax) or any other FHCP approved means. **I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization that I must do so in writing and present my written revocation to an FHCP Medical Records Department. I understand that the revocation will not apply to information that has already been released as requested by this authorization. I understand that any disclosure of information carries with it the potential for redisclosure where confidentiality laws or regulations may not apply. It also prohibits FHCP from making any further disclosure without the specific written authorization of the person to whom it pertains. I understand that FHCP will not condition treatment, payment, enrollment, or eligibility for benefits on whether or not I sign this authorization.**

Release of PHI Expiration Date: (Must either circle or enter an "Expiration Date")
☐ Upon Death Or Expiration Date / / Or ☐ one year from the date of signature

_____ _____
Signature of Patient or Legal Representative/Authorized Health Surrogate* Date

_____ _____
Witness Date

*****Legal Representative/Authorized health Care Surrogate is defined as a court appointed guardian or personal representative, a person with a Health Care Power of Attorney specific to medical records access, a person designated as a Health Care Surrogate, or next of kin. Supporting documentation required.

FEES FOR COPYING AND/OR REVIEWING OF FHCP ARE AVAILABLE UPON REQUEST. PLEASE ALLOW SUFFICIENT TIME FOR COPYING AND/OR SCHEDULING A REVIEW OF MEDICAL INFORMATION (72 HOUR MINIMUM PROCESSING TIME).

Completed form can be returned by mail to the address at the top of this page, by fax to the number(s) at the top of this page, or scanned and sent by email to medrecroi@fhcp.com.