

**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 \_\_\_\_\_

<input type="checkbox"/> Myself	<input type="checkbox"/> Family Member Name:
<input type="checkbox"/> Family Member Name:	<input type="checkbox"/> Facility / Hospital / Doctor:
<input type="checkbox"/> Family Member Name:	<input type="checkbox"/> 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.

<input type="checkbox"/> Office Visits	<input type="checkbox"/> Operative Reports	<input type="checkbox"/> Labs/Date drawn _____
<input type="checkbox"/> Immunizations	<input type="checkbox"/> Radiology Reports	<input type="checkbox"/> Other _____

Date(s) of Service: \_\_\_\_\_ **Pertinent information may be faxed for emergent need only.**  
**If this Sensitive Information is checked, the patient must initial.**

<input type="checkbox"/> HIV/AIDS information _____	<input type="checkbox"/> Drug and Alcohol _____	<input type="checkbox"/> Psychiatric _____	<input type="checkbox"/> Other _____
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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).**