

\$1.00 Per page / Personal USE

Authorization to Use or Disclose Protected Health Information

- Morton Plant Hospital
- Mease Countryside Hospital
- Mease Dunedin Hospital
- Morton Plant North Bay Hospital

I hereby authorize the above hospital(s) to use or disclose the following information from the health records of the individual whose name is described below.

Please print:

Patient Name: _____ Date of Birth: _____

Address: _____
(city) (state) (Zip)

Phone Number _____ Social Security # _____

I authorize the above hospital(s) to release medical, mental, alcohol and/or drug abuse, HIV (human immunodeficiency virus) testing, AIDS, eating disorders or any other medical information of a sensitive nature to the following individual(s) or organization(s):

Name: _____

Address: _____
(city) (state) (Zip)

- This information for which I'm authorizing disclosure will be used for the following purpose:
 Description: _____

Dates of service to be released: _____

The type of information to be used or disclosed is as follows (check the appropriate boxes and include other information where indicated)

- Abstract
- Discharge Summary
- History and Physical reports
- Operative Reports
- Consultation Reports
- Progress Notes
- Lab results/X-Ray and imaging
- Emergency Room Records
- Other: (please describe) _____

I understand that if the organization authorized to receive the information is not a health plan or healthcare provider, the released information may no longer be protected by Federal privacy regulations. I understand that I need not sign this authorization to ensure treatment. This authorization shall remain valid for six months from the date signed below.

I understand that I have a 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 department or facility listed on the authorization. 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.

Signed _____ Date _____

Patient or Authorized Person, Parent () Legal Guardian () Executor () Power of Attorney ()

- Photo ID checked

Witness _____ Date _____

Copied by: _____ Date: _____ Pages copied: _____

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please return to:

**MORTON PLANT HOSPITAL
 MEDICAL RECORDS
 DOCUMENT SERVICES
 815 CHESTNUT ST.
 CLEARWATER, FL 33756**