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's Name		Date of Birth	Medical Record #
Patient's Address	City	State	Zip
Phone #		☐ Check if patient is an employee of UF Health Shands	

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

From the doctor, office, facility of other health care provider checked or written below:	To the facility / person below:
☐ **Specialty, Physician or Hospital:**	☐ **Check here if same as patient** ☐ **Check here for records pick-up only**
Clinic, person or organization	Clinic, person or organization
Address	Address Fax
Phone Attn	Phone Attn

Please check appropriate facility and mail or fax completed forms to:	**UF Health HIM Dept – ROI** P.O. Box 100348 Gainesville, FL 32610-0348 Phone: 352.594.0909 Fax: 352.265.1098	☐ **UF Health Shands Hospital** ☐ **UF Health Shands Rehab Hospital** ☐ **UF Health Shands Psychiatric Hospital** ☐ **UF Health Florida Recovery Center**	☐ **UF Health Clinics** ▪ Specific Clinic: ☐ **UF Health Shands HomeCare** 1610 NW 23rd Avenue, Gainesville, FL 32605 Phone: 352.265.0789 ▪ Fax: 352.265.9276

The following PHI may be released *(check boxes below)*:			**I further authorize the release of the following information which may be included in the PHI:**
☐ History and Physical	☐ Operative Report(s)	☐ Discharge Summary	☐ Behavioral Health
☐ Problem List	☐ Medication List	☐ Clinic/Office Notes	☐ Substance Use Disorder
☐ Emergency Room Record	☐ Radiology Reports	☐ Lab/Pathology Reports	☐ STD/HIV/AIDS Treatment(s) or Test(s)
☐ Billing Records	☐ Radiology Images	☐ Other:_____	☐ 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 ☐ Personal Use ☐ Legal ☐ Other: _____
Format of Records?	☐ MyUFHealth (UF Health Portal) ☐ CD ☐ Paper

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 use, 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. pts 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.
- 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 redisclosed by the person or entity that receives it.
- I am aware that I may be charged a fee for this request as allowed by law, which may include up to $1.00 per page (plus applicable tax and handling) for Paper Records and fees associated with labor, supplies (i.e. cost of a computer disk), and postage for Electronic Records. Fees are waived when PHI is released to a health care provider for treatment purposes.

_____ **Signature of patient / patient representative** _____ **Date**

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 (Internal use only)	Verification of Authority (Internal use only)

UFHealth SHANDS UF UNIVERSITY of FLORIDA

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