UF Health Flagler Hospital
Health Information Department
400 Health Park Blvd.
St. Augustine, FL 32086
Phone: 904.819.4410 Fax: 904.819.4915
roi@flaglerhealth.org
https://ufhealth/medical-records.org

AUTHORIZATION FOR UF HEALTH FLAGLER HOSPITAL TO RELEASE MEDICAL INFORMATION

Patient Name:			Birth Date:
Address:			
City:	State:	Zip:	Tele No.:

I hereby authorize UF Health Flagler Hospital to release my medical information to:

Recipient Name:				Tele No.:
Address:	City:	State:	Zip:	Fax No.:

Documents Needed:
❑Abstract (includes physician documents, test results, emergency room report)
❑Radiology Images/CD
❑Other____

Dates of Service: ❑All ❑Last Visit Only ❑From: ____/____/____ To: ____/____/____

Purpose of Release: ❑Insurance ❑Legal (Attorney) ❑Continued Care ❑Disability ❑Personal

Doctors appointment on ________________date __________________time

I am aware that such records may contain, but are not limited to, information related to mental health, substance abuse (both alcohol and drug) and sexually transmitted diseases (including test results related to HIV/AIDS), and I specifically authorize the release of such information pursuant to this Authorization.

I understand that this authorization will remain in effect for one (1) year, but I may revoke it at any time in writing. I further understand that any such revocation will not apply to any information already released under this Authorization. I understand that I am under no obligation to sign this Authorization, and that my ability to obtain treatment from UF Health Flagler Hospital will not depend in any way on whether I sign this Authorization. I understand that I have a right to receive a copy of this Authorization.

I understand that state and federal law may prohibit the recipient from re-disclosing information provided pursuant to this Authorization but UF Health Flagler Hospital has no control over the recipient and cannot guarantee that the recipient will not re-disclose such information. I hereby release UF Health Flagler Hospital from any and all liability related to their reliance upon this Authorization or the release of information pursuant to this Authorization.

Patient Signature: ____ Date: ____________

If the legal representative, sign below and state relationship and authority to do so and attach a copy of the document of authority.

Legal Representative:____ Date: _____________

Authority/Relationship: ____

OFFICIAL USE ONLY:

MRN#________________________ REQUEST# ____

INSTRUCTIONS: