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 #	Verification of Identity
			☐ Driver License/State ID ☐ Personally known ☐ Other:
Patient's Address / City / State / Zip			
Phone #	Last 4 digits of SSN (Optional)		☐ Check if patient is an employee of UF Health Shands

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	Verification of Authority

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:

☐ **University of Florida** person, class of persons, or organization:

Clinic, person, class of persons, or organization

Address

Phone Attn

☐ **UF Health Shands Hospital** ▪ PO Box 100345, Gainesville, FL 32610-0345
Phone: 352.265.0131 ▪ Fax: 352.265.1098

☐ **UF Health Shands Rehab Hospital** ▪ 4101 NW 89th Boulevard, Gainesville, FL 32606
Phone: 352.265.5491 ▪ Fax: 352.627.4425

☐ **UF Health Shands Psychiatric Hospital** ▪ 4101 NW 89th Boulevard, Gainesville, FL 32606
Phone: 352.265.5497 ▪ Fax: 352.627.4425

☐ **UF Health Florida Recovery Center** ▪ 4001 SW 13th Street, Gainesville, FL 32608
Phone: 352.265.5500 ▪ Fax: 352.265.5504

☐ **UF Health Shands HomeCare** ▪ 3515 NW 98th Street, Gainesville, FL 32606
Phone: 352.265.0789 ▪ Fax: 352.265.9276

To the facility / person below:

Clinic, person, class of persons, or organization

Address and Fax Number

☐ Check here if same as patient
☐ Check here for records pick-up only

Attn:

The following PHI may be released *(describe in detail or use the check boxes below)*:			**I further authorize the release of the following information which may be included in the PHI:**
☐ History and Physical	☐ Operative Reports(s)	☐ Discharge Summary	☐ Mental Health/Psychiatric Treatment
☐ Problem List	☐ Medication List	☐ Treatment Notes	☐ Alcohol or Substance Abuse Treatment
☐ Emergency Room Record	☐ Radiology Reports/Films	☐ Lab/Pathology Reports	☐ STD/HIV/AIDS Treatment(s) or Test(s)
			☐ 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 ☐ Other:
Format of Records?	☐ Through a web portal, with notice provided to my e-mail account at: _____ To request records in electronic PDF form, please check the box above and provide a valid and clear e-mail address. You will receive an e-mail from HealthPort and that e-mail will tell you how to get the records. ☐ 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 abuse, HIV/AIDS, and STDs.
- 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, if I do so in 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 re-disclosed 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** _____

UFHealth UNIVERSITY OF FLORIDA HEALTH UF UNIVERSITY of FLORIDA

Authorization for Use or Disclosure of Protected Health Information

Distribution: Original – Patient Record; Copy – Requestor

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