

# NORTH SHORE Medical Center

1100 NW 95<sup>TH</sup> STREET, MIAMI, FL 33150

HEALTH INFORMATION MANAGEMENT DEPARTMENT

PHONE: 305 835-6179 FAX: 305 694-3624

## AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

Patient's Name: \_\_\_\_\_  
Last First Middle

Home Address: \_\_\_\_\_

Home Telephone: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

SPECIFY INFORMATION TO BE DISCLOSED: **The information that may be disclosed under this Authorization includes:**

- |   |  |   |                                |
|---|--|---|--------------------------------|
| <input type="checkbox"/> Discharge          | <input type="checkbox"/> Pathology                 | <input type="checkbox"/> Emergency              |                                |
| <input type="checkbox"/> History & Physical | <input type="checkbox"/> Radiology                 | <input type="checkbox"/> Holter Monitor Reports |                                |
| <input type="checkbox"/> Consultations      | <input type="checkbox"/> Laboratory                | <input type="checkbox"/> Rehab (PT, OT, ST)     |                                |
| <input type="checkbox"/> Operative Reports  | <input type="checkbox"/> ECHO / EEG / EKG (circle) | <input type="checkbox"/> Mammogram Report       | <input type="checkbox"/> Other |

Please provide date of service being requested: \_\_\_\_\_

### MY HIGHLY CONFIDENTIAL INFORMATION:

By checking any of the boxes next to a category of highly confidential information listed below, I specifically authorize the use and/or disclosure of the category of highly confidential information indicated next to the box, if any such information will be used or disclosed pursuant to this Authorization:

- Information about mental health or mental retardation services
- Psychotherapy Notes created by a mental health professional
- Information about HIV/AIDS-related testing (including the fact that an HIV test was ordered, performed or reported, regardless of whether the results of such tests were positive or negative)
- Information about sexually transmitted diseases
- Information about alcohol or drug abuse treatment program services
- Information about sexual assault
- Information about child abuse and neglect **OR**  Abuse of an adult with a disability

RECEIPT: **Name of person or class of persons to whom North Shore Medical Center may disclose my health information:**

Address of the recipient or where my health information should be delivered: \_\_\_\_\_

- Do Not Mail: records will be picked up (if mailed, enclose a valid government issued picture ID)

TERM: **This Authorization will remain in effect:**

- From the date of this Authorization until the \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_.
- Until North Shore Medical Center fulfills this request.
- Until the following event occurs: \_\_\_\_\_
- Other: \_\_\_\_\_

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## AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

PURPOSE: I authorize North Shore Medical Center to use or disclose my health information (including the highly confidential information I selected above, if any) during the term of this Authorization for the following specific purpose(s): [Note: "at the request of the Patient" is sufficient if the Patient is initiating this Authorization] \_\_\_\_\_

I understand that once North Shore Medical Center discloses my health information to the recipient, North Shore Medical Center cannot guarantee that the recipient will not re-disclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.

I understand that North Shore Medical Center may, directly or indirectly, receive remuneration from a third party in connection with the use or disclosure of my health information.

I understand that may I refuse to sign or may revoke (at any time) this Authorization for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of my treatment at North Shore Medical Center except, however, if my treatment at North Shore Medical Center is for the sole purpose of creating health information for disclosure to the recipient identified in this Authorization, in which case North Shore Medical Center may refuse to treat me if I do not sign this Authorization.

I understand that this Authorization will remain in effect until the term of this Authorization expires or I provide a written notice of revocation to North Shore Medical Center's Privacy Office at the address listed below. The revocation will be effective immediately upon North Shore Medical Center's receipt of my written notice, except that the revocation will not have any effect on any action taken by North Shore Medical Center in reliance on this Authorization before it received my written notice of revocation.

I may contact hospital's Privacy Officer by mail at the Health Information Management Department, 1100 NW 95<sup>th</sup> Street, Miami, FL 33150 OR by telephone at (305) 835-6000, Extension 6584.

I have read and understand the terms of this Authorization and I have had an opportunity to ask questions about the use and disclosure of my health information. By my signature, I hereby knowingly and voluntarily authorize North Shore Medical Center to use or disclose my health information in the manner described above.

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date

Note: If Patient is a minor or is otherwise unable to sign this Authorization, obtain the following signatures:

\_\_\_\_\_  
Signature of Authorized Personal Representative

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Date

**For Internal Use Only:** The identity of the requestor has been validated either with a government issued picture ID, such as a driver's license or passport, or comparison of signatures documented in the PHI records.

\_\_\_\_\_  
Signature of Employee Validating Identity

\_\_\_\_\_  
Patient's Medical Record Number