Health Care District
OF PALM BEACH COUNTY
WE CARE FOR ALL

Authorization for Release of Medical Records

Service Area	☐ **Community Health Center** ☐ **Lakeside Medical Center** ☐ **Skilled Nursing Center** ☐ **Trauma Hawk** ☐ **Ground Transportation**				
Patient's Name		**Date of Birth**		**Medical Record #:**	
Address					
Email		**Phone #:**			
Verification of Identity (Government Issued Identification –					

By signing this form, I authorize the following: **DATE RANGES:** _____

Disclosure of the patient's PHI from:		**Disclosure of the patient's PHI to:**	
Person, class of person, and/or organization		Person, class of person, and/or organization Health Care District -Community Health Centers	
Address		Address 1515 N Flagler Drive STE 101 WPB FL 33401	
Fax	Phone	Fax 561 804 5643	Email recordsrequest@hcdpbc.org

The following protected health information may be disclosed: (check appropriate box or boxes)

☐ **Lab Result** _____ ☐ **PAP Result** _____ ☐ **Diagnostic/Imaging Result** _____

☐ **Progress Note** _____ ☐ **Medication List** ☐ **Vaccination History/Records** ☐ **Consult Notes**

☐ **Hospital/Emergency Department D/C Summary** ☐ **Other:** __ _____

I further authorize the disclosure of the following information, which may be included in the protected health information listed above (Check and initial all that are approved)

☐ **Mental Health**: _____ ***(initial)***	☐ **HIV/AIDS:** _____ ***(initial)***
The purpose of the disclosure is:	

a. I understand that, by federal law, Health Care District of Palm Beach County and affiliated entities, including, but not limited to, Community Health Center, Lakeside Medical Center, Skilled Nursing Center, Trauma Hawk, and Ground Transportation may not use or disclose protected health information without authorization except as provided in the Notice of Privacy Practices. By signing this Authorization, I am giving permission for the uses and disclosures of the described protected health information. I hereby release The Health Care District of Palm Beach County, affiliated entities, and its employees from any and all liability that may arise from the release of information as I have directed.

b. I understand that I have the right to revoke this Authorization at any time, if I do so in writing, and address it to the person or institution named above. I understand that the revocation will not apply to any actions already taken as a result of this authorization.

c. I understand that The Health Care District of Palm Beach County and affiliated entities may not condition treatment, payment, enrollment or eligibility of benefits on the completion of this Authorization.

d. I understand that information disclosed pursuant to this Authorization may no longer be protected by the federal medical privacy law and could be disclosed by the person or agency that receives it.

e. I understand that I have the right to obtain, upon request, a list of entities to which my information has been disclosed.

f. If The Health Care District of Palm Beach County or its affiliated entity has requested this Authorization, I understand that The Health Care District of Palm Beach County or affiliated entity will give me a copy of this Authorization form upon my completion with signature included.

This authorization expires automatically one (1) year from the date signed if no other date or event is specified.	**Expiration Date or Event:**
I have read and understand the information in this authorization form.	
Printed Name and Signature of Patient or Legal Representative	**Date:**
Printed Name and Signature of Witness	**Date:**