



ST. LUCIE MEDICAL CENTER
 HEALTH INFORMATION MANAGEMENT
 1800 SE TIFFANY AVENUE
 PORT SAINT LUCIE, FL 34952
 772-335-4000 X 3249
 FAX: 772-398-3763



Section A: This section must be completed for all Authorizations					
Patient Name:		Birth Date:		Social Security No. (optional): XXX-XX	
Provider's Name: ST. LUCIE MEDICAL CENTER		Recipient's Name:			
Provider's Address:		Address:			
1800 SE Tiffany Avenue		City:		State:	Zip:
Port St. Lucie, FL 34952		Phone #:		X-Ray#:	
This authorization will expire on the following: (Fill in the Date or the Event but not both.) Date: _____ Event: _____					
Purpose of disclosure:					
Description of information to be used or disclosed					
Is this request for psychotherapy notes? <input type="checkbox"/> Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. <input type="checkbox"/> No, then you may check as many items below as you need.					
Description:	Date(s):	Description:	Date(s):	Description:	Date(s):
<input type="checkbox"/> ABSTRACT OF RECORD <input type="checkbox"/> Admission form <input type="checkbox"/> Transfer forms <input type="checkbox"/> Dictated Reports <input type="checkbox"/> Laboratory Tests <input type="checkbox"/> Imaging Results <input type="checkbox"/> Diagnostic Images		<input type="checkbox"/> Operative Information <input type="checkbox"/> Cath lab <input type="checkbox"/> EKG <input type="checkbox"/> Other Diagnostic Tests <input type="checkbox"/> Medication Sheets <input type="checkbox"/> ER Information <input type="checkbox"/> Nursing Documentation		<input type="checkbox"/> Labor/delivery summary <input type="checkbox"/> OB documentation <input type="checkbox"/> Itemized bill <input type="checkbox"/> UB-92: <input type="checkbox"/> Other:	
I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. _____ (Initial) If not applicable, check here. <input type="checkbox"/>					
I understand that: 1. I may refuse to sign this authorization and that it is strictly voluntary. 2. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization. 3. I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices. 4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed. 5. I understand that I may see and obtain a copy the information described on this form, for a reasonable copy fee, if I ask for it. 6. I get a copy of this form after I sign it.					
Section B: Is the request of PHI for the purpose of marketing?					
If yes, the health plan or health care provider must complete Section B, otherwise skip to Section C.					
Will the recipient receive financial or in-kind compensation in exchange for using or disclosing this information?				<input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, describe:					
Section C: Signatures					
I have read the above and authorize the disclosure of the protected health information as stated.					
Signature of Patient/Patient's Representative:				Date:	
Print Name of Patient's Representative:				Relationship to Patient:	

AUTHORIZATION FOR RELEASE OF INFORMATION

