



449 West 23rd Street, Panama City, Florida 32406
(850) 747-7906 Fax (850) 747-7128

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I authorize Gulf Coast Medical Center to release information to:

Address: _____

Reason for Release: _____

Patient Name: _____ Date of Visit: _____

SS# _____ Date of Birth _____ Phone # _____

Requestor Name: _____

Please Check All Appropriate Blanks:

_____ Medical Abstract (Includes facesheet, Discharge Summary, History & Physical, Operative, Radiology and Pathology reports)

_____ X-ray reports _____ Surgical Procedure report _____ Medication Record

_____ Laboratory reports _____ Physician Progress Notes _____ Entire Medical Record

_____ Consultation reports _____ Nursing Notes _____ Other: _____

I understand that this release may include information relating to Acquired Immune Deficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV), treatment for drug or alcohol abuse, mental or behavioral health or psychiatric care. Any release of this information must be pursuant to 42 CFR and other Florida State Statutes.

I understand that Gulf Coast Medical Center (GCMC) may charge a fee for the costs of copying (\$1.00 per page), mailing and other supplies associated with this request as authorized by Florida State Statute 395.3025.

I authorize _____ to pick up my records.

I understand that I may refuse to sign this authorization and that it is strictly voluntary. I understand that my treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization. I understand that this consent is revocable upon written notice to the hospital, unless action has already been taken on this authorization, and that this authorization shall remain in force for a six month period in order to effect the purpose for which it is given. I understand that information disclosed pursuant to the authorization may be redisclosed by the recipient and no longer protected by federal privacy regulations. Release of this information may be in several different forms, including verbal, written, audio, or electronic media (i.e.: fax, U.S. mail, FedEx, etc).

Printed Name of Patient

Patient Representative

Witness

Signature of Patient

Authority to Act for Patient

Date

Date

Date