CALHOUN LIBERTY HOSPITAL
A TALLAHASSEE MEMORIAL HEALTHCARE AFFILIATE

AUTHORIZATION FOR RELEASE OF INFORMATION

16257 State Road 71 South Blountstown, FL 32424

PATIENT INFORMATION
Date(s) of Service Requested:

____/____/_____ to

____/____/_____

NAME: _____ DATE OF BIRTH: ____/____/___

LAST 4 NUMBERS OF SSN: _____ DAY PHONE: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

EMAIL: _____

PLEASE FILL IN ALL AREAS

RELEASING PARTY

*(**Who** has the information you want released?)*

☐ Calhoun Liberty Hospital

☐ Calhoun Liberty Hospital EMS (Ambulance Services)

☐ Calhoun Liberty Hospital Primary Care Clinic (Rural Health Clinic)

RECEIVING PARTY

*(**Where** do you want the information sent?)*
*(**Who** may have the information?)*

NAME: _____

ADDRESS: _____ DAY PHONE: _____

CITY: _____ STATE: _____ ZIP CODE: _____

FAX NUMBER: _____ **(URGENT CARE PATIENT ONLY)**

PLEASE FILL IN ALL AREAS

HOSPITAL (Check all that apply):

- ☐ Hospital Summary
- ☐ Discharge Summary
- ☐ History and Physical
- ☐ Laboratory Reports
- ☐ Emergency Record
- ☐ Cardiac Reports / EKG
- ☐ Consultation Reports
- ☐ Radiology Reports
- ☐ Entire Record (not including psychotherapy notes)
- ☐ Other: _____

OFFICE/CLINIC (Check all that apply):

- ☐ Office Visits
- ☐ Immunizations
- ☐ Physical Exams
- ☐ Entire Record (not including psychotherapy notes)
- ☐ Laboratory Reports
- ☐ Radiology Reports
- ☐ Clinic Summary
- ☐ Other: _____

EMS (Check all that apply):

- ☐ Run Reports*

**We are only able to provide run reports where the patient was brought to CLH via our ambulance service*

FORMAT: ☐ CD ☐ PAPER ☐ Other: _____

DELIVERY METHOD: ☐ Mail ☐ Pick-up ☐ Fax, where permitted

PATIENT'S RIGHTS - I understand that: 1) I can cancel this permission at any time. I must cancel in writing to the Privacy Officer at the above address. **2)** Any cancellation will apply only to information not yet released by CLH. **3)** Once my health information is released, there is the potential for information disclosed pursuant to this authorization to be subject to re-disclosure by the recipient and no longer protected by applicable regulations. **4)** Refusing to sign this form will not prevent my ability to get treatment. **5)** CLH will not share or use my health information without my permission other than the ways listed in CLH's Notice of Privacy Practices or as required by law. The Notice of Privacy Practices is available at calhounlibertyhospital.com. **6)** A fee may be charged for providing the protected health information. **7)** I have a right to receive a copy of this form upon my request.

I DO NOT WANT TO RELEASE (check all that apply):

☐ **HIV/AIDS** ☐ **GENETIC INFORMATION** ☐ **SEXUALLY TRANSMITTED DISEASE (STD)** ☐ **DRUG/ALCOHOL** ☐ **MENTAL HEALTH**

This permission expires one year after the date of my signature unless another date or event is written here:

Signature: _____ Print Name: _____ Date: _____

Witness Signature: _____ Print Name: _____ Date: _____

Note: If a minor consented for their outpatient treatment for pregnancy, STD, or behavioral / mental health without parental consent, the minor must sign this authorization.

Note: If the patient lacks the legal capacity or is unable to sign, an authorized personal representative may sign this form. Check the box below to indicate the relationship / authority ***(Written Proof May Be Requested)*** :

☐ Healthcare Agent / POA ☐ Guardian ☐ Spouse ☐ Executor / Administrator / Attorney in Fact

☐ Parent ☐ Adult Child ☐ Affidavit Next of Kin ☐ Other: _____