Authorization for Use or Disclosure of Protected Health Information

I hereby authorize Moffitt Cancer Center to <u>release</u> my Medical Records/Protected Heath Information to the organization/provider listed below:

Name or organization:	Fax:		Phone:
Email:	Mailing	address:	
. ,		<i>or</i> from:	to: , labs, radiology, pathology report, EKG's)
[] Billing Records	History & Physical	[] Outside Records	[] Physician Orders
[] Consultation Reports	Laboratory Results	[] Pathology Reports	[] Progress Notes
[] Discharge Summary	Pathology Slides	[] Operative Reports	[] Radiology Reports
	Genetic Records [] Radiology Imaging (CT_PET_Mammogram_Ultrasound_MRI_X-Ray)		
[] Other specific record(s). Please describe:			
[] Exclude the information expressly listed below (if blank, then no information is excluded):			
Purpose of Disclosure: The above information is released for the following purpose (please check the appropriate box) [] Transfer of medical care [] Legal/Attorney use [] Personal [] Insurance use [] Continuity of care This authorization will expire on: If no date is given, this authorization will expire in 90 days.			
This authorization will expire on: If no date is given, this authorization will expire in 90 days. Records being released to patients may stay active for up to 1 (one) year from the date signed all other recipients can stay active for up 90 days from the date the release is signed.			
I understand in compliance with Florida law, there may be fees for requesting copies of my medical record. I understand I may revoke this Authorization at any time by notifying the Health Information Management (HIM) Department of the Center in writing, except to the extent that the Hospital has taken action in reliance on this Authorization. I understand that I may refuse to sign this Authorization and that my refusal to sign will not affect my ability to obtain treatment, payment, or my eligibility for benefits. I understand the information disclosed under this Authorization may be subject to redisclosure by the recipient and no longer protected by federal privacy regulations or other privacy laws. I understand by signing this Authorization I authorize the Hospital to disclose the information identified above.			
Signature of Patient or Personal Rep	presentative D	Printed Name of Pat	ient or Personal Representative Date
Description of Personal Representat	ive D	ate	
MOFFITT (M)		Pa	atient Name:

EMR: Release of Information
12902 Magnolia Dr. Tampa FI 33612 MBC-HIM
PHONE: 813-745-3991 FAX 813-449-8001
Medicalrecordrequest@moffitt.org

Date of Birth:____